Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

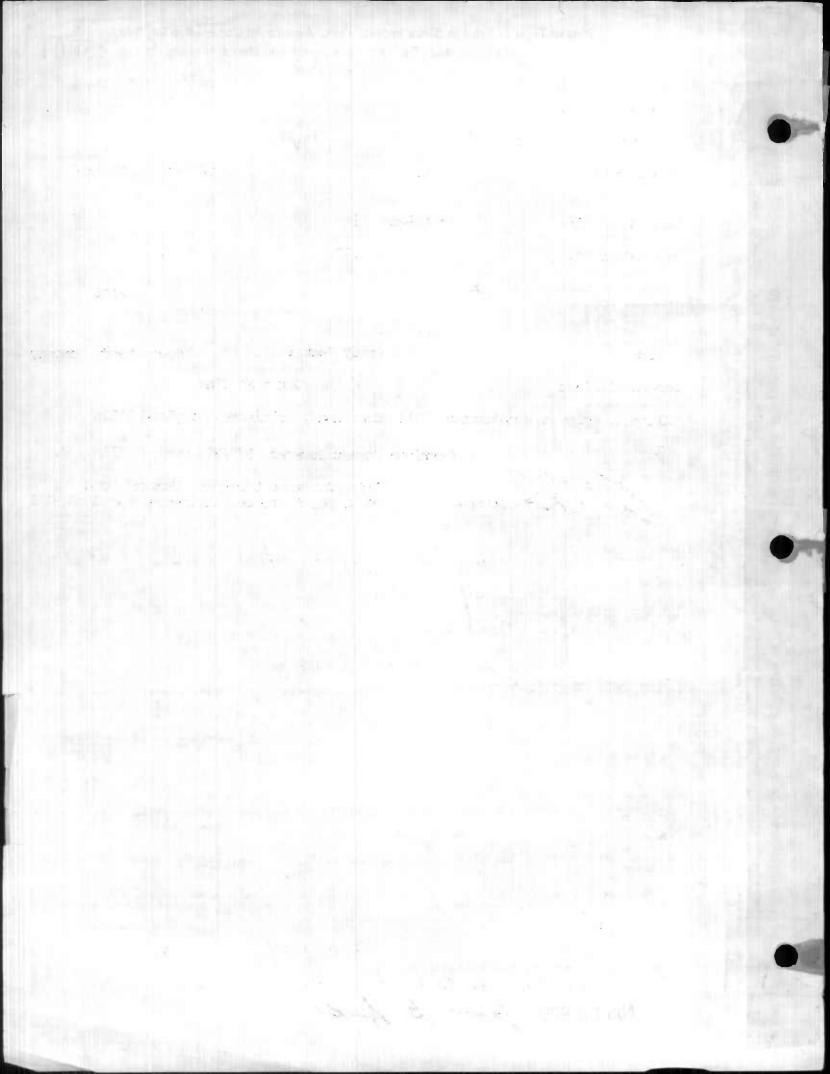
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent'a Name (First, Middle, Last) Month **Physician** 0430 ara Coleman /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Mercy Medica Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03 06 1936 9. Birthplece (State or Foreign Maryland 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1 □ M 2 🕏 👍 Days Hours 63 Yrs. 219-28-2209 Director Usual Residenca of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at Yes 2 No Director Baltimore City Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number U.S.A. 21218 3914 Ednor Road death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11. Maritel Stetus filed within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ XNo Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. permit. Pagas 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other th any Injury or other traumatic event, the page. Candy Packer Goetz Candy Company llth 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dorie Mc Tier Joseph Williams 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 3914 Ednor Road, Baltimore, Maryland 21218 19e. Informant's Name/Relationship (Type, Print) Milton S. Coleman, Sr/Husband 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremetion 3 Remove from State Garrison Forest Cemetery 8/9/99 Owning Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funant 22. Name and Address of Fecility William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Maryland 21217 Lallun Approximate Interval Between Onset and Deeth The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel 20 days disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Insufficience attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca of): The law requires that the death certificate be execu Preumonia Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) use as t organ signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen certificata has 2 No 1 Yes 1 Yes 2 No Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Unpatient 2 ER/Outpetient 3 DOA 10 Nospital or Attending Physical 24 hours after death.

Funeral Director: After this or funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Yes 2 No that 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 - Homicide 29a, Certifie 1 Certifying Phyalcian: To the best of my knowledge, death occurrad at the time, date and place, and due to the cause(s) and manner as stated. edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of continu 29c. License number 29d. Date signed (Month, Day, Year) 0005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 210 Burk Bldg Swore 301 lhomes 31. Dete filed (Month, Day, Year) Registrar's Signeture State AUG 1 0 1999

DHMH 16 Rev 6/95

Registra



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MOHAMMAD Y, KHAN, M.D. 900 CATON MUENUE, BALTIMORE, MARYLAND 21229	Medical Certification: To Be Completed by Physician/Medical Examination Control Contro	medieta Causa seese or condition sulting in death) quentially list cony, laading to in use. Enter Unduse (Diseese or at initiated avant under III. Other eigniful ava	ficant conditions, mediate entrying sinjury street to medical ficant conditions. Fig. 1. So Pending investigated Could not determined The certifying 2 Medicat External ficant Medicat Ext	a. ANC. b. RECU c. SEP d. ACU contributing to M. D(S) Hospital: 1 28a. Det (MC) ion be 28e. Ple buil Physician: To the aminar: On the end me	Due to CRENT Due to TIC SM Dua to TE MYDO death but not re EASE, PE Impatient 2 e of Injury Atding, atc. (Spa ne bast of my ke basis of exemilations reled.	ER/Outpet thome, farm, sicily) ES(DENT teem 23a) (Type	PATHY equence of) equence of) equence of) equence of) equence of) equence of) AC ARI equence of) equence of) for ARI equence of) for ARI equence of) equence of) for ARI equence of)	SECUL SECUL Cause g SCUL OA OI 28c. Injury, offica	ing, such as cerding, such as cerding. IDN IDN iven in Pert I. 26. Place of Dithar: 4 Nursing and the continued of the	23b. DI 24e. We pe 24e. We pe 15eth (Check ont) Home 5 The 28f. Location City or 1	d tobecco use of the course of	contribute to 3 Pro 24b. W av con 1 [Other (Special curred) mannar as s e, end due to med (Month,	Approximete Interval Between Onset and Deeth Onset and Deeth 72 Hours 24 Hours II DAYS 10 DAYS 10 DAYS 10 The ceuse of death? The bebly 4 Unknown Varia autopsy findings callable prior to ompletion of ceuse deeth? 11 Yes 22 No 15 No 16

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day HELEN GRACE CARAWAY **AUGUST 6 1999** 11:20am 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 622 N Woodward Drive Essex Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Dec. 22, 1920 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Days 1 □ M 2 X F Months Hours 216-16-9824 78 MAry land Usual Residence of Dacedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Essex 1 Yes & No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 622 N Wooodward Drive 21221 USA 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Bace - American Indian. Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes ZX No Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Hutzler's 12th 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) John Botzon Emma Johnson

20b. Placa of Disposition (Name of cemetery, crematory or other placa)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

622 N Woodward Drive Baltimore Md. 21221

20c. Location - City or Town, State

Baltimore Md.

Intervel Batween Onset end Death

24b. Wara autopsy findings avelleble prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 1 No

the Marylend r than "natural", or itame 23a or 28a-1 show the Medical Examiner must be notified at death filed within 72 hours after Baltimore, Maryland 21215-0020 Hygiene. other permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic eventians.

Physician

/Medical

Examiner

10a State

Director

Funeral

þ

Completed

Be

2

Md.

19a. Informant's Name/Raiationship (Type, Print)

20a. Method of Disposition

James Caraway / husband

Funeral

Director

1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State 8/9/99 Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensae 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part1. Entar tha disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only see cause on each line. 300 Mace Ave. Baltimore Md. 21221 **Physiclan** Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Dua ja (or as a Box 68760 Physician/Medicai 88 ò signed by the a Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed by 24a. Was an autopsy performed? peen The law has paga 2 1 Yes certificate Division of Vital or Attanding Physician: director, Be 25. Was case referred to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Mesidence 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death. Prineral Director: A pletaty filled in by the fo 2 Accident investigation 3 Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Spacify) 4 Homicide Hospital Medical 29a. Cartifier 1 Certifying Phyalclan. To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner es stated. (Check only one) On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. To the Vithin 2 29b. Signature and title of ca 29c. License number 29d. Date signad (Mghth, Day, Yaar) 30. Nama and addrass of person

State Registrar

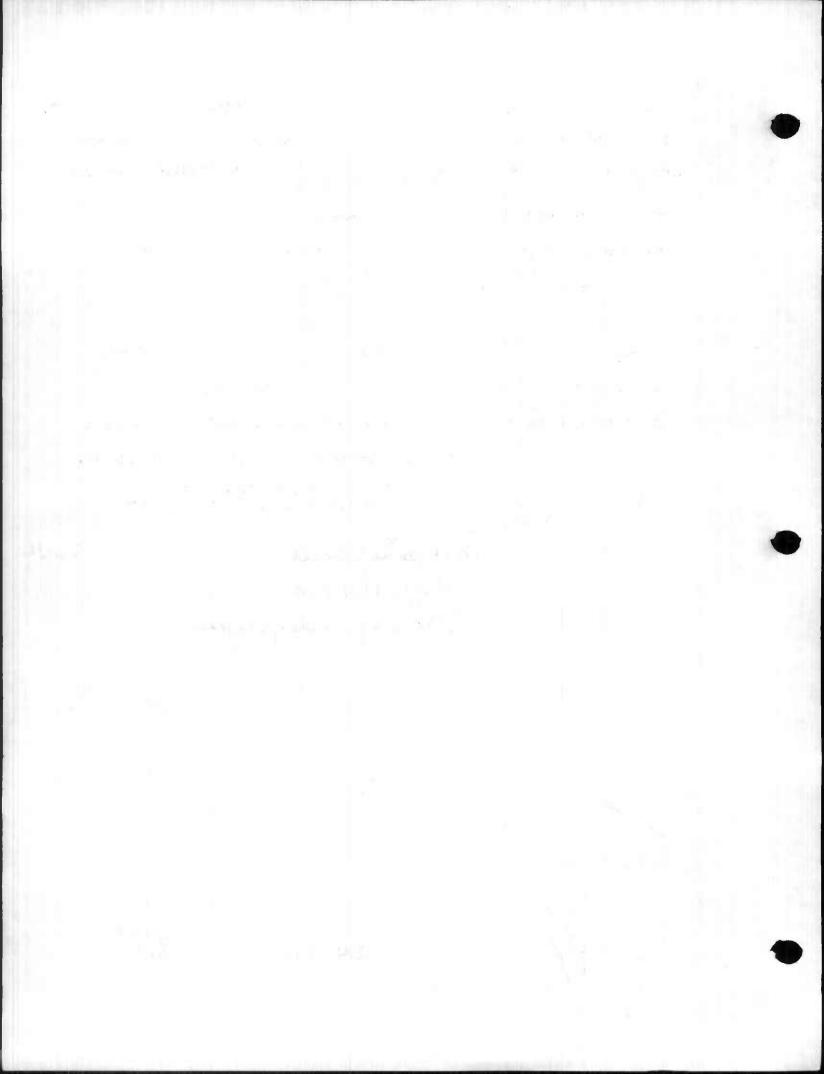
31. Date filad (Month, Day, Yaar) AUG 10 1999

Dr. Ali Sanal

6730 Holabird Aux Balto 32. Registrar's Signatura

o complated causa of death (Itam 23a) (Typa, Print)

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 45 August 12 a.m 1999 Earl Carlton 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Mercy-Stella Maris Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours XXM 2 F Yrs 09 26 N.C. 246-46-1004 66 Usuel Residence of Deceden 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County 1 Yes 2 □ No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4032 Edgewood Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 2 1 2 1 5 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) U.S.A. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 Yes 2XXIo Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 6th grade Laborer Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Florence Rufus Carlton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21215 Janice L. Carlton-Wife 4032 Edgewood Road, Baltimore Md 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/11/99 Randallstown, Md King Memorial Park 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility March F/H West nanng 4300 Wabash Ave, Baltimore Md 4300 Wabash Ave, Baltimo notificition thi caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, one cause on each line. Approximate Intervel Between Onset and Death Part1. Enter the disease, or compliants shock, or heart failure. Immediate Cause (Final Metrodutic disease or condition resulting in death) Lurgagent Due to (or as a consequence of) Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 1 Nos 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy parformed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 | Nursing Home 5 | Residence & Other (Specify) has pay 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Neturel 2 Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and menner as stated. | Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate the security

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or litems 23a or 28a-f sho the Medical Examiner must be notified at

Hygiene.

Pages 1 and 2 should be III ment of Health and Mental H ant. If feen 27 is marked oth

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Physician /Medical

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29b. Signature and title of cartified

32. Registrer's Signeture

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30. Name and address of person who completed ceuse of death (Item 23e) (Typa, Print)

B. Sporks

29c. License number

St Paul Pl

D40854

29d. Date signed (Month, Day, Year)

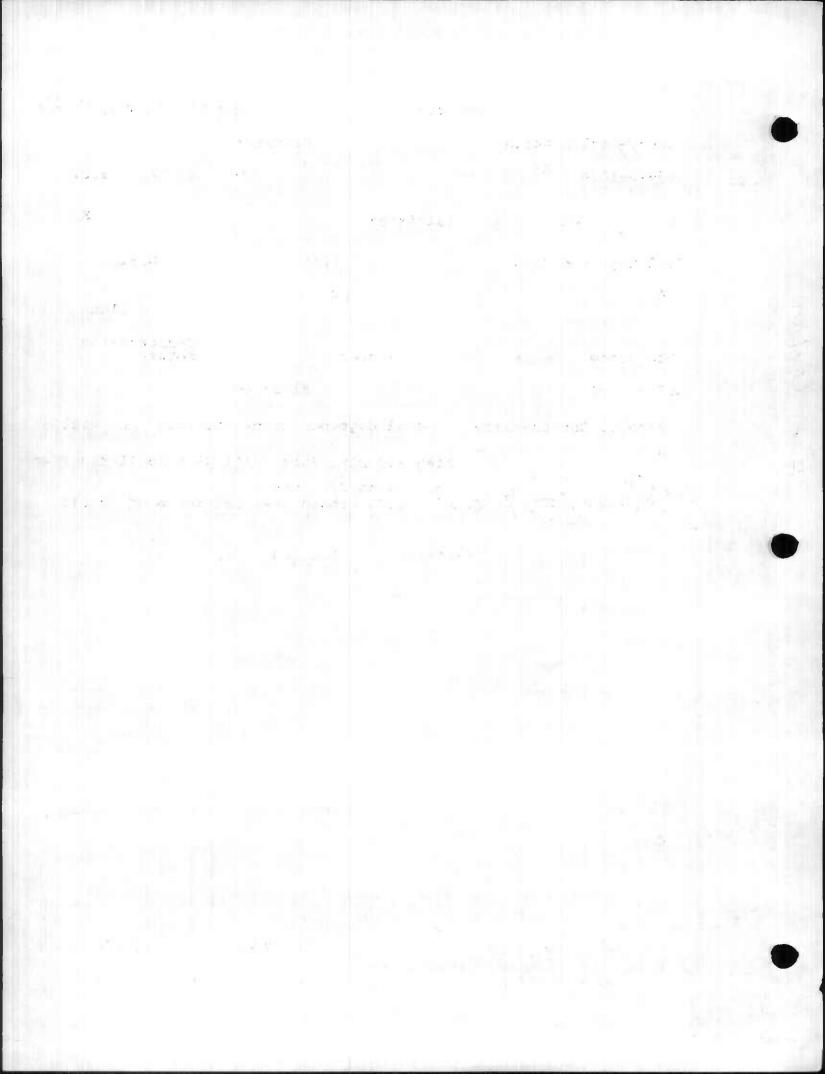
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Tima of Death Month **Physician** 1999 1:00 am Nan Estelle Cullen August /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millinneum Health & Rehab at South River Anne Arundel Edgewater 7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 8. Data of Birth (Month, Day, Year) July 21, 1905 Birthplace (Stata or Foreign Country) **Funeral** Days 10 M 2 F Virginia 212-36-9834 94 Director Usual Residence of Decedent the Mandand 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD Anne Arundel 1 ☐ Yes 2 No Harwood Director r than "natural", or leans 23s or 25s-f the Medical Examiner must be notifie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Polling House Road 20776 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, White, etc. filed within 72 hours after Hygiene. Wher then "natural", or its 1 Yes 2000 1 Never Married 2 Married 21215-0020 1 ☐ Yas 2 TNo Specify: Specify: à White 3 ☐Widowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be lited w
Department of Health and Mental Hygien
Important if Item 27 is marked other the
any injury or other traumatic. 12 Homemaker Own Home Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be Thomas Digges Brown Estelle C. Robinson 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 106 Polling House Road, Harwood, MD 20776 Nanette Phyllis Johnston 20b. Place of Disposition (Nama of 20a. Method of Disposition Data 20c. Location - City or Town, Stata Camatary, crematory or other place)
National Memorial Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/09 Fairfax, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Nama and Addrass of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 or complications that caused the deeth. Do not entar the moda of dying, such as cardiac or raspiratory arrest, only one cause on each line. Approximeta Intarval Batween Onsat and Death **Physician** Less than Immediata Causa (Final disease or condition resulting in death) /Medical CARDIAC ARRHYTHMIA 10 minutes Examiner MORE THAN Physician/Medical Examine SICK SYNDROME SINUS YEAR physician and s the burief-transit the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): MORE THAN CORONARY ARTERY Box 68760. DISEASE 1 YEAR Dua to (or as a consequence of) 8 P.O. signed by the e Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ The law requires 24b. Wara autopsy findings available prior to completion of cause of daeth? been si 24e. Was en autopsy performed? Completed 2 No 1 Yas 1 Yas 2 No of Vital Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only ona) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To P S 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending 1 Natural 5 Pending investigation s effer des. 1 TYas 2 No 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 T Homicide 6 Hospital 24 hours edical To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

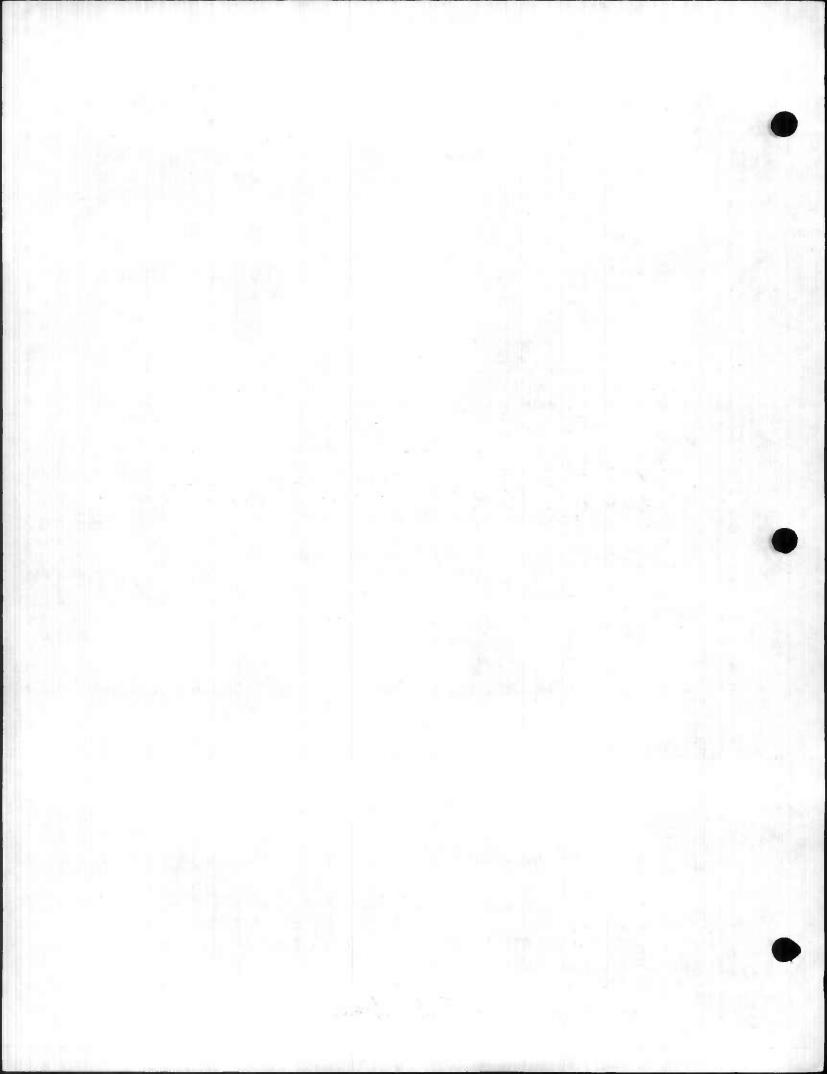
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. Licensa number 29d. Deta signed (Month, Day, Year) 29b. Signature and title of certifier Eyanchord Finana. D 50653 8-6-1999 SURANA GYAN CHAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 DEALE CHURCHTON ROAD DEALE MD 20751 31. Data filed (Month, Day, Year)

Registrar

State

AUG 1 0 1999

32. Registrar's Signatura souls



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month RALPH 3:20 PM DIETRICK 999 **AUGUST** I HOM AS 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not Institution, give street and number) BALTIMORE CENTER N/A HARBOR HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 30, 1922 If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex Days 1₩ M 2□ F Months 577 24 4125 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limita 10a. Stete 10b. County 1 ☐ Yes 2 ☑ No Baltimore Maryland Anne Arundel 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 929 - 1st Street 21225 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? 1⊠ Yes 2 □ No If Yes, Give Yeer or Detes: ₩. ₩. II 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify 3X Widowed 4 □ Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Model Maker Naval Research 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wilfred J. Dietrick Mary Hoque 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Neme/Relationship (Type, Print) Donna Brooks / Daughter 1209 Tillerman Place Baltimore, Maryland 21226 20b. Pieca of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriei 2 ☐ Cremetion 3 ☐ Removel from State Cedar Hill Cemetery 8/9/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name end Address of Facility 21. Signature of Funerel Service Licenses Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. romuselsky 21225 23a. Part. Enter the disease, or complete lons thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only the cause on each line. Approximate interval Between Onsef and Death Immediate Ceuse (Finel CARDIAC FAILURE MONTH disease or condition resulting in deeth) 2 WEEKS RENAL FAILURE Due to (or es a consequenca of) UNDERLYING CORON ARY Due to (or es a consequence of) 23b. Dfd tobacco use contribute to the cause of desth? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 28. Place of Death (Check only one) Hospital: inpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

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attending physician

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page 2 :

funeral director.

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Hospital 24 hours

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certificate be executed

P.O. Box 68760,

Records,

Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medicai

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Certification:

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Funeral

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or its

other i

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Maryland 21215-0020

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Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury fhat initiated events resulting in deeth) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Manner of Deeth Natural 5 Pending Investigation 2 Accident

6 Could not be determined 3 ☐ Suicide 4 - Homlcide

28a. Dete of fnjury (Month, Day Year) 28b. Time of

28e. Piace of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury af Work? 2 No 1 Yes

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of cestif

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) and menner as atated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner ateted. 29c. License number 29d. Date signed (Month, Day, Year)

PGY-1 RESIDENT OF INTERNAL MEDICINE

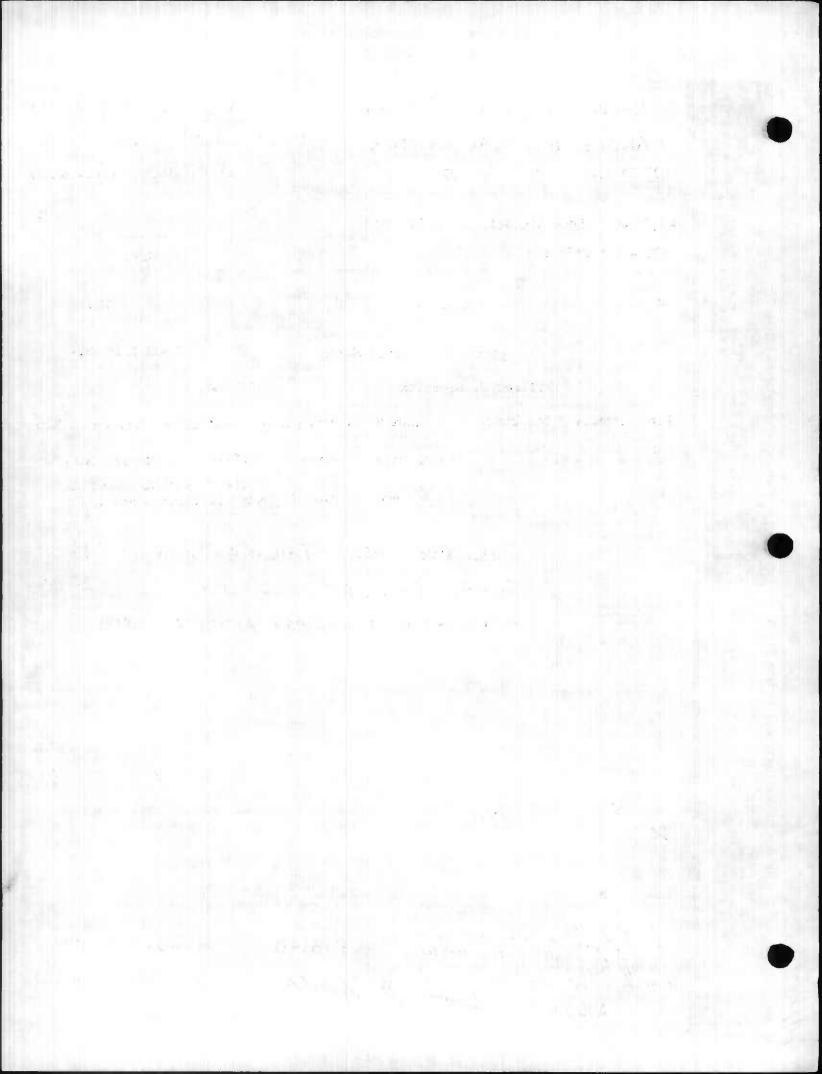
AUGUST

ess of person who completed cause of deeth (Item 23e) (Type, Print)

3001 SOUTH HANOYER BYREET, BALTIMORE, MARYLAND 21225 MD BADE 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 0 1999

State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DANIEL **Physician** GENEVA AUGUST 09, 1999 03:45AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 8. Date of Birth (Month, Day, Year) 08 02 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Yrs. 70 Director 238-46-6581 29 N.C. Usual Rasidence of Decedent worle 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1X Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21213 2103 Sinclair Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Detes: 14. Raca - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours efter to Department of Healith and Mental Hygiene.

Important: If item 27 is marked other than "natural", or fiel my Injury or other traumatic event, the Medical Energian. 1 ☐ Never Married 2 X Married Maryland 21215-0020 1 ☐ Yes XXNo Specify: P Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Private Domestic 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Sarah Savage Robert Epps 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1432 Carwell St., Baltimore Md Bilal Hassan-Son Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Wurial 2 Cremetion 3 Removal from State 8/11/99 Randallstown, King Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility March F/H West Pan Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA ONE HOUR Examiner Due to (or as a consequence of) Physician/Medical Examiner HYPOTENSION ONE DAY The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician s the buria SEPSIS THREE DAYS Due to (or as a consequence of) MAK INFECTION THREE Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL STAGE DISEASE bed i þ Records. 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en autopsy performed? HYPERTENSION MELLITUS 1 Yes 2 No 1 ☐ Yes 2 No DIABETES certificate of Vital Hospital or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) exeminer? Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Aftar 5 Pending investigation 1 Neturel ster death. 1 ☐ Yes 2 ☐ No 2 Accident illed in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated. edlcai 29a. Certifier (Check only one) completely Within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES-000 AUGUST 9, 1999

A DHWH

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

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JAMES M SIZEMORE

AUG 1 0 1999 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

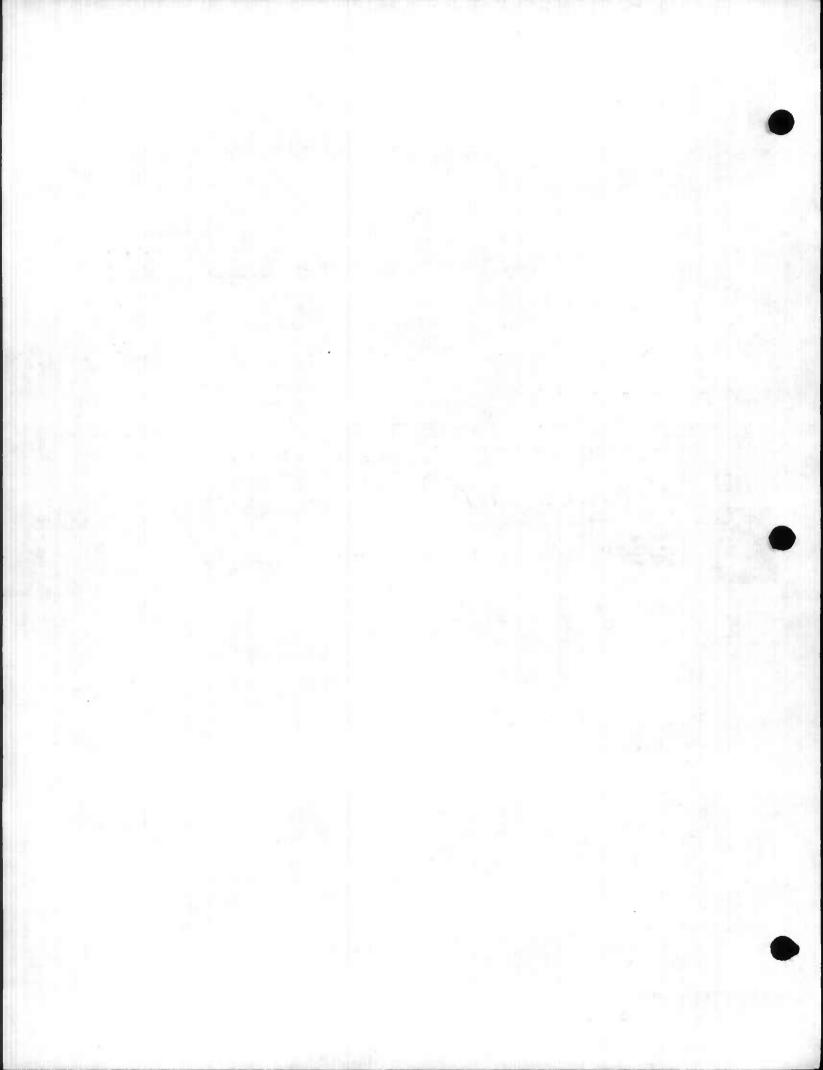
E JR MD

32. Registrar's Signature

A. Sparks

JOHNS HOPKINS HOSPITAL 110 TOWER BALTIMORE MO 21287

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) Month August John Ehinger 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Stella Maris Hospice at Mercy Baltimore n/a If Under 24 Hrs. Hours Min. If Under 1 Year 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplece (Stata or Foraign Country) 1√2 M 2□ F Months Days Yrs 181 40 7828 52 April 27,1947 Maryland Usual Rasidence of Decedent 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location 1 ☐ Yas 2 No Baltimore Maryland Essex 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1624 Cape May Rd. 21221 United States 12. Was Decedent Ever In U,S. Armed Forcas? 1 X Yas 2 □ No It Yas, Giva Yaar or Detes: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian Black, Whita, atc. 1X Never Married 2 ☐ Marriad 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 5+ 12 Sales Representative Retail 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumema) William Albert Ehinger Henrietta May Morrison 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Darlyn E. Brown / Sister 1624 Cape May Rd., Baltimore, MD 21221 20e. Mathod of Disposition 20b. Place of Disposition (Neme of camatary, cramatory or other place) 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Ramoval from State Dulaney Valley Mem. Park 8/12/99 4 ☐ Donetion 5 ☐ Other (Specify) Timonium, MD 22. Name and Addrass of Facility CAFA Stephen D. Lohrmann P.A. 23a. Part 1. Entot tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Dr., Baltimore, MD 21286 Approximeta Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) 4 Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

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page 2 s certificate hes

requires that the death certificete be execu

Box 68760,

Division of Vital Records.

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Physician/Medical

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r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death v. Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, tra Medical Examiner man and DOGE.

altimore, Maryland 21215-0020

Directo

Funeral

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Sequantially list conditions, if any, laading to immediate causa. Enter Underlying Ceuse (Disaasa or Injury that initiated avants rasulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Plece of Death (Chack only one S. + E | A

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Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 5 Panding Invastigation

28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Spacify)

Other: 4 Nursing Homa 5 Rasidance 6 Stathar (Specify) HOSpicE 28c. Injury at Work? 1 Yas 2 No

28d. Dascribe how injury occurred 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

(Check only

Netural 2 Accident

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Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

31. Data filad (Month, Day, Year)

29d. Dete signed (Month, Day, Year)

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

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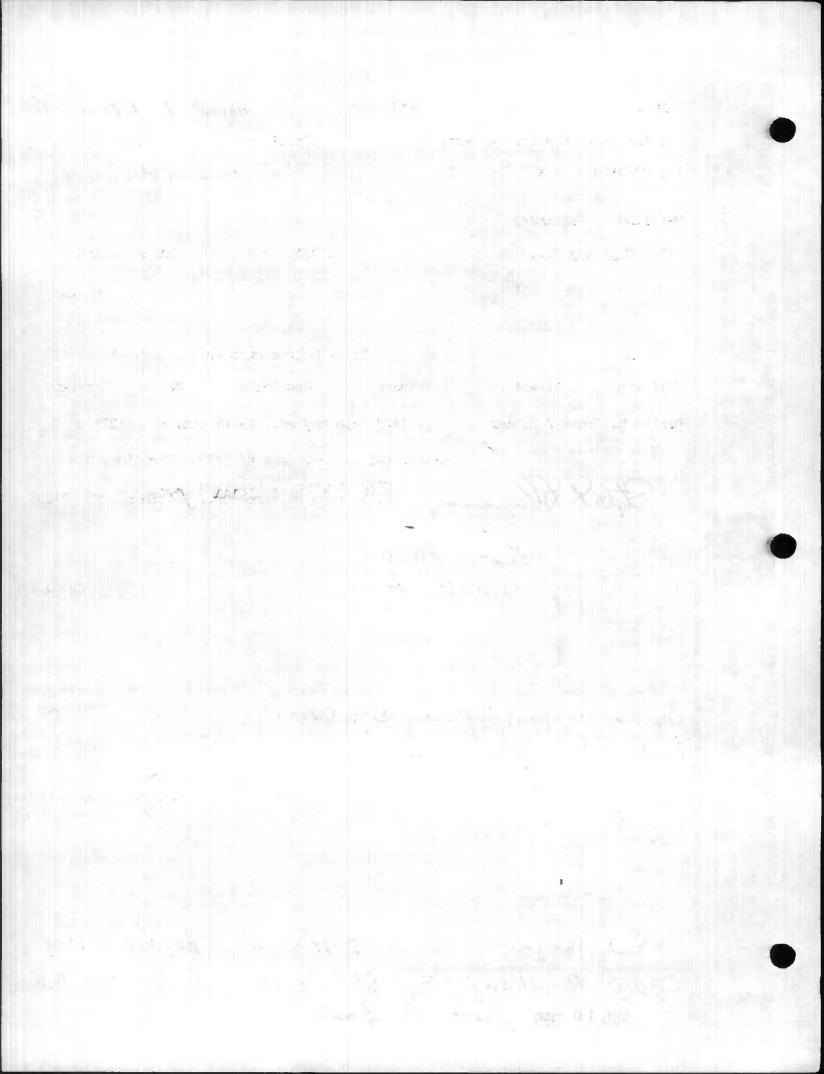
State Registrar

AUG 1 0 1999

6 Could not be determined

32. Ragistrar's Signature

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM#19a PER F.H. G774 8-17-99 J.A. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death GREENSFELDER **Physician** AUGUST 8:51Am WILLIAM HOWARD /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner AC day) If Under Months City Baltimore City BALTIMORE ar If Under 24 Hrs. 8. C 24 Hrs. 8. Dete of Birth Min. (Month, Day) April 29 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days 218-28-4947 1₽M 2□F 67 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medical Examinar must be notified at 10a Stete 10b County 10d. Inside City Limits MD 1 Ves 2 □ No Director Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1052 Bunbury Way 21205 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⅓ Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Stetus permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or hen any injury or other traumatic avant, the Hedges Exercised pages. Bleck, White, etc. 1 Never Merried 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. P 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 State of Maryland Security Guard 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) George Greensfelder Unknown 19e. Informent's Neme/Relationship (Type, Print) FRIEND 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia Ann Szypula 1052 Bunbury Way, Baltimore, MD 21205 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removet from State Metro Crematory Aug7 1999 Catonsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funerel Service Licenses Charlton Challe 2007 Eastern Avenue, Baltimore, MD 21231

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest, Approximata tntervel Between Onset end Death **Physician** tramediete Cause (Finel disease or condition resulting in death) /Medical ASPIRATION PNEUMONIA Examiner Examiner WEEK DIMINISHED MENTAL STATUS attending physician end for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) ENCEPHALOPATHY IWEEK HEPATIC Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of) YEARS ALCOHOL LIVER MISEASE 23b. Did tobacco use contribute to the cause of death? Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitet: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Netural 28b. Time of 28d. Describe how Injury occurred To the Hospital or Attanding Pt within 24 hours after death. To the Funeral Director: After it completely filled in by the funera edical Certification: 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 8 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifie (Check only one)

JR JAMES M SIZEMORE

29d. Date signed (Month, Day, Year) AUGUST

30. Neme and address of person who completed cause of death (ttem 23a) (Type, Print)

JOHNS HOPKINS HOSPITAL 110 TOWER BALTIMORE, MD 21287

State Registrar

AUG 1 0 1999

29b. Signeture and title of certifier

31. Dete filed (Month, Day, Year)

32. Registrar's Signature

oaks

29c. License number

RES-000

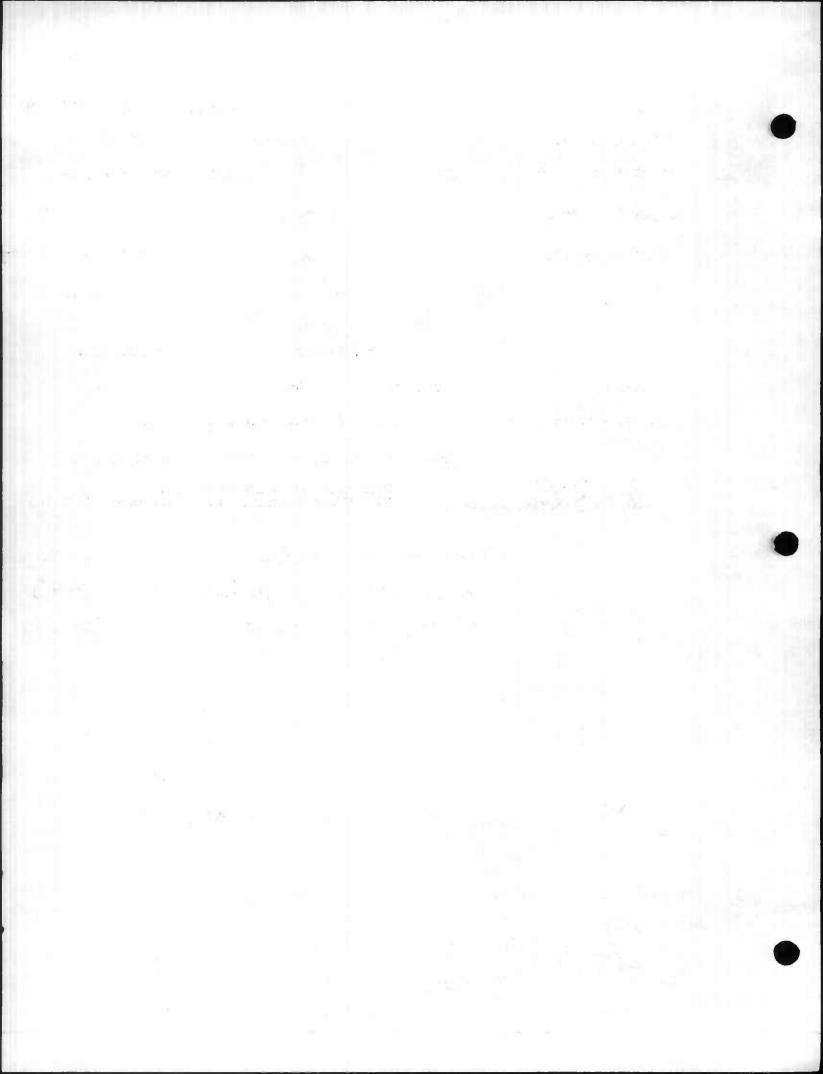
pape à l'alla

Physician /Medical Examiner

Edwin 1999 12:40 AM August 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 13623 Bardon Rd. Phoenix Baltimore 5. Sociel Security Number If Under 1 Year 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months 1 X M 2 ☐ F Deys Hours 212 05 2844 92 April 3,1907 Director Maryland Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Llmits r than "natural", or Items 23a or 28a-f shorthe Mexical Examples in the Mexical Examples of the profiled at 1 Yes XX No Baltimore Phoenix Maryland Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13623 Bardon Rd. 21131 United States Items 23a death 11 Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Bleck, White, etc. filed within 72 hours efter 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 1 Divorced "natural', Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Meter Reader Utility Co. 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: If Item 27 is marked oth any liqury or other traumatic event anse. 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Griffin (Unknown) Anne Page 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) James G. Griffin / Son 13623 Bardon Rd., Phoenix, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from State 8/9/99 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory Baltimore, MD 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on each line. 21286 Approximate Intervel Between Onset end Deeth **Physician** Congestive Host Failure /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner brance obstacctore pulmoran disere physician end s the buriel-transit Sequentielty list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Coronan Box 68760. Physician/Medical Due to (or es a consequence of): for use es 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Records, P.O. É 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were eutopsy findings eveitable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peeu page 2 s 2 0 No certificate 1 Yes 1 Yes 2 No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certification by the funeral director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of Naturet 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number. City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

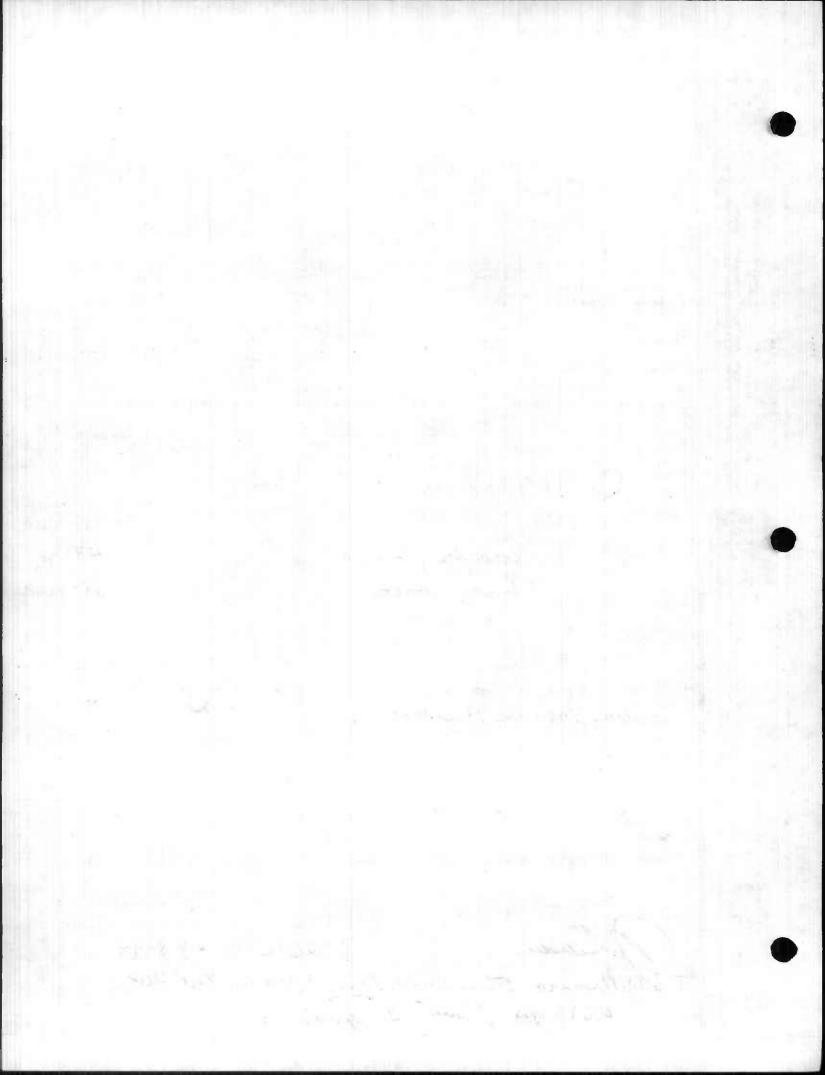
Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. edical 29e. Certifier (Check only one) To the Vithin 2 To the Complet 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) leted cause of death (Item 23e) (Type, Print) 30. Name and address of person who co 110 32. Registrar's Signature State

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

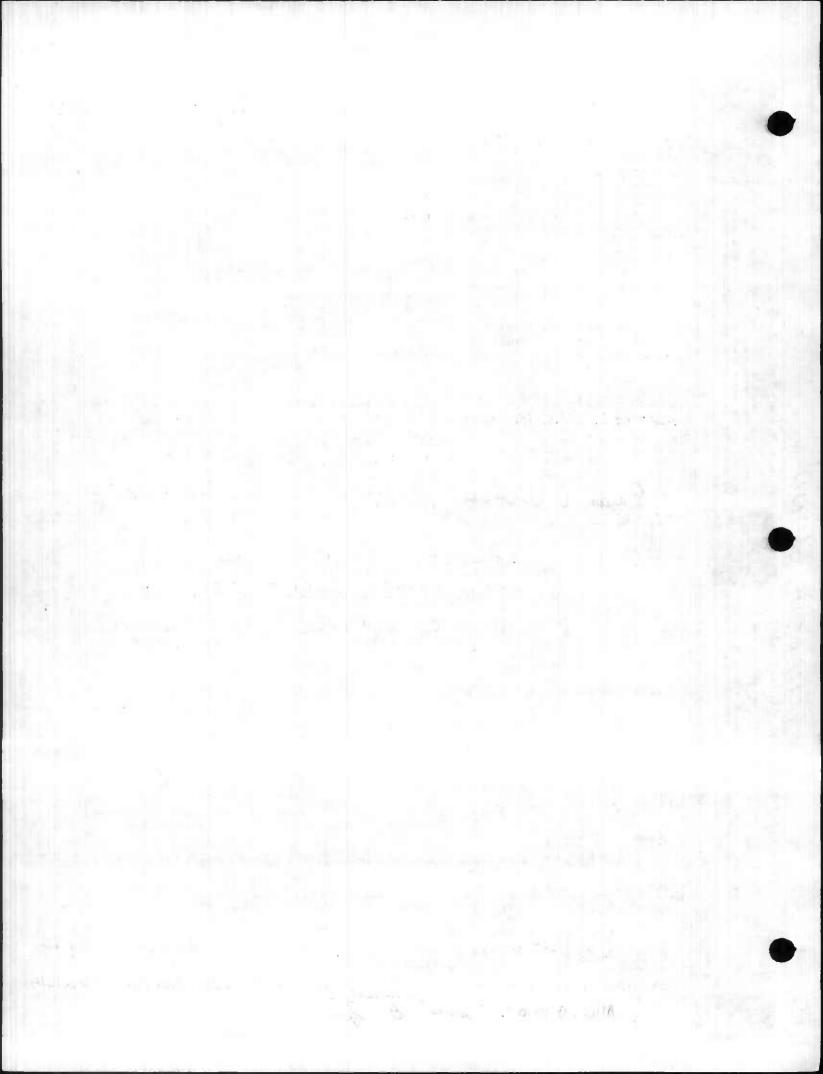
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		Suburban Hospi						hesd		Mont	gom	ery	
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Division of Vital necords, P.O. Dox 66/60,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Marlos Carifordian To Be Commissed by Dhushing Indian Evening

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	4a Facility Nama (If not		a street and no	ımber)			4b. City, Town, or L			of Death	
ı	Fallston G	oneral.	Hospit	al.			Fallsto	on	Harfo	rd	
	5. Social Security Numb	ber 6. S	ax	7. Aga (In yrs	. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of B		9. Birthpl	lace (Steta or Fo
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Н		b. County		10c. C	City, Town or I	ocation				10	0d. Inside City Li
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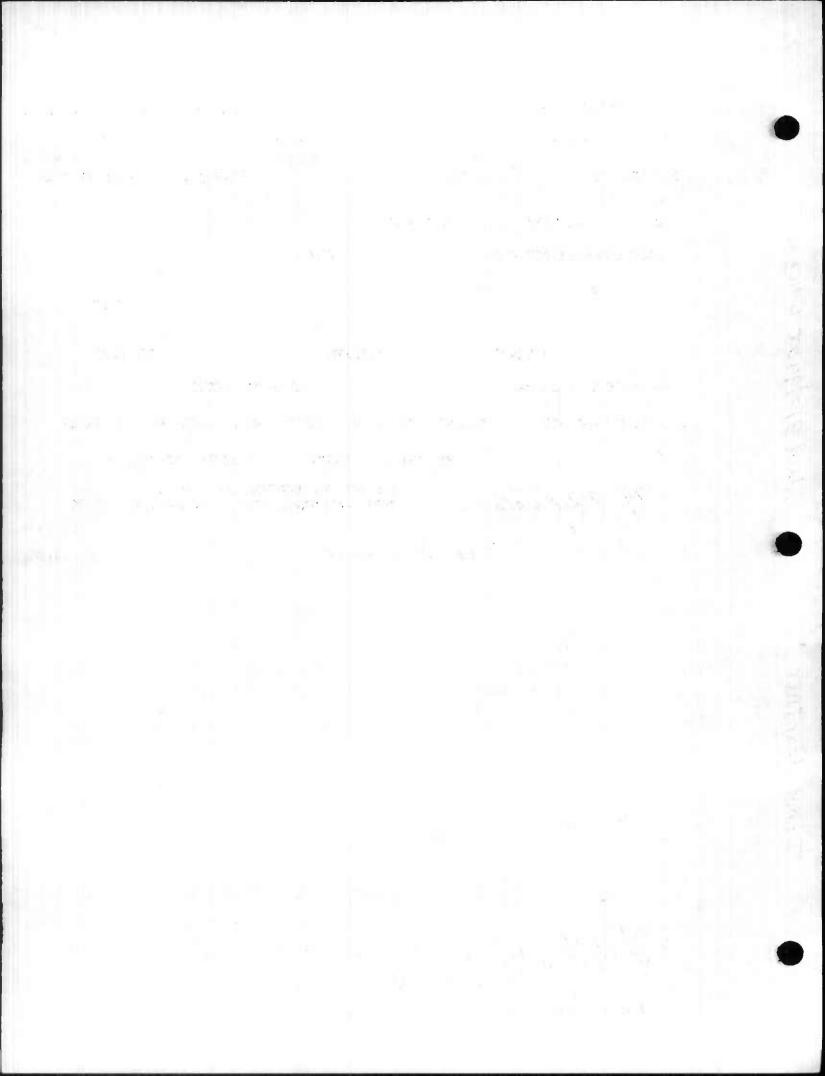


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State of Maryland / Department of Health and Mental Hygiene 9

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					Ce	rtificate (of L	Death		F	leg. No).			
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Exami	ner	4a. Facility Nama (If not institution GILCREST CENT.		number)			4	to. City, Tow		ocation of Daath	40	BAL.	of Death	RE	
Funeral Director		5. Social Sacurity Numbar 213-52-4871 Usual Rasidanca of Dacadent	6. Sax 1 ☐ M 2 🔀		n yrs. last birthday) Yrs.		aar ays	If Under: Hours	24 Hrs. Min.	8. Data of Birth (Month, Day 12/22/	, Year,)	Cou	placa (Stata or Foraig ntry) NSYLVANIA	n
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毎 る 数	Director	10a. Street and Number 11300 OLD CAN	RRIAGE RO	מאַכ		10f. Zip Co	da 1.05	57		T	-	tizan of V	Vhat Cou	ntry?	
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permit. Pa Departmen Important: any injury SMSE.		21. Signature of Funaral Sarvice	Licensaa	0	ין		NSC	N FUI	VERA	L HOME,	P.	Α.			
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/Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in daeth)	е		east (a to (or as a conse		8						/	14 month	نه
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ling Affer fune	Certification: T									MHOSPICE					
	Certifi	4 Homicida detem	nined 288. Pl	28a. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify)				28f. Location (Street and Number or Rural Routa Number, City or Town, State)							
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Item 27 is marked other than "naturel", or items 23a or 28a-f show other treumstic event, the Medical Examinar must be nothed at

2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "naturel", or lier

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m

Physician /Medical

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After this funeral

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Certification:

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Baltimore, Maryland 21215-0020

that the death certificate be exec Hospital or Attending Physicien:

DHMH 16 Rev 6/95

State Registrar

9200 Franklin 31. Dete filed (Month, Day, Year) AUG 10

29b. Signature end title of cartifier



30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Dr.

MD

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Balto.

53462 Jude Muneses

29c. License number

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29d. Date signed (Month, Day, Year)

MD 21237

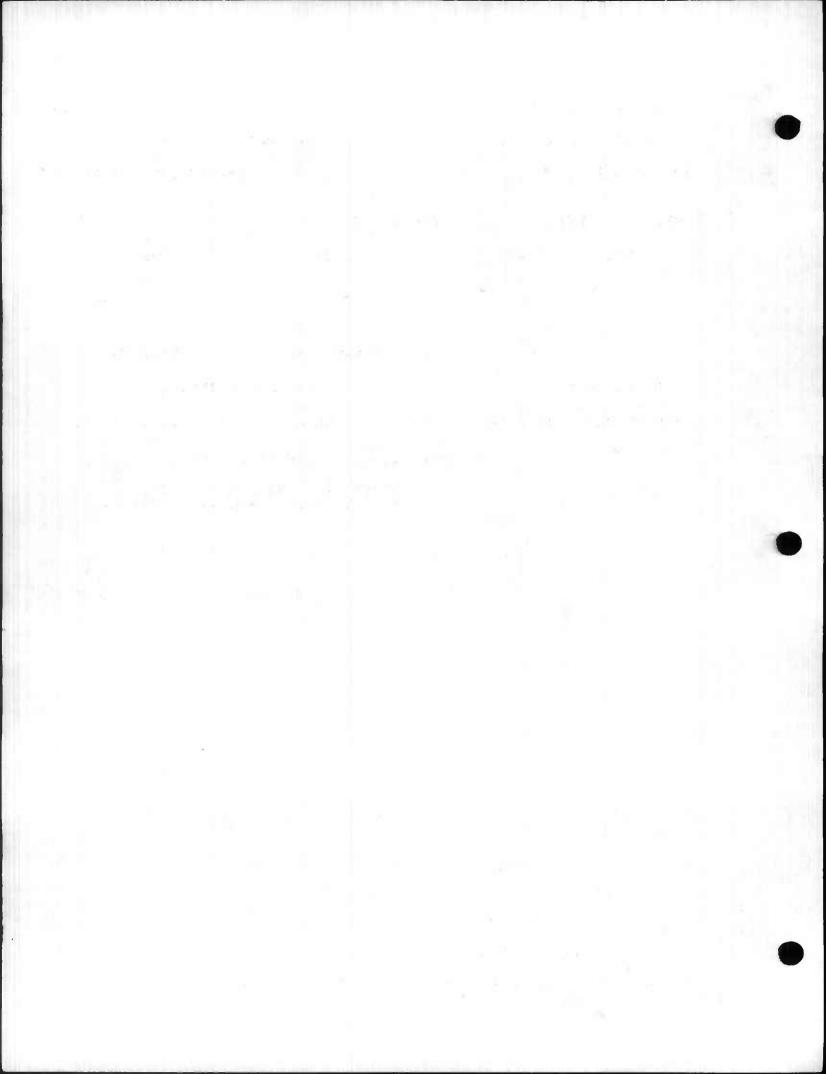
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** Month 05, ROBERT 1999 E. AUG. 4:35AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 5210 ST. ALBANS WAY BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 MM 2 □ F Yrs. 08/09/1933 NEW JERSEY 143-24-4313 65 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r is marked other than "natural", or items 23s or 28s-f shoo traumatic event, the Medical Examiner must be notified as 1 Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5210 ST. ALBANS WAY 21212 USA Pages 1 and 2 should be filed within 72 hours after deeth nent of Heelth end Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ INVESTMENT BANKER BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN F. HUNT REGINA SCHILLING 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2: Department of Heelth er Important: if Item 27 is any Injury or other traugings. ANN MURPHY HUNT (WIFE) 5210 ST. ALBANS WAY, BALTO., MD. 21212. 20b. Place of Disposition (Neme of cemetery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 8/9/99 BALTO., MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical MYELDID Examiner Due to (or as a consequence of): Physician/Medical Examiner Myelodys plastic physicien end the burial-transit the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of) Box 68760, Due to (or as a consequence of) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy page 1 ☐ Yes 2 ☐ No certificata Division of Vital Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Dete of Injury (Month, Day Year) 28d. Bescribe how Injury occurred 27. Manner of Death 28c. Injury at Work? A hours after dee... or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 24 hours 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune complately f (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 0 MA out of person who completed cause of death (Item 23a) (Type, Print) STEVEN GORE M.D., JOHNS HOPKINS ONCOLOGY CENTER, BALTO., MD. 31. Date filed AND D.A. Ar 32. Registra 's Signature State

DHMH 16 Rev 6/95

Registrar



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	5. Sociel Security Number 245 - 12 - 2743	6. Sex 7. And 1	ge (In yrs. last b		Wonths Day		Min. 8. Da	te of Birth onth, Day,	924 S	9. Birthplac Country	ce (State or Fore
	Usual Residence of Decedent		T40 05 T							1	
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al Director	10e. Street and Number 3811 Norfork Ave	.			10f. Zip Code 21216				g. Citizen of V nited S		
by Funeral	11. Meritel Stetus 1 Never Married 2 Merrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2F If Yes, Give Year or Dates:	Ever in U.S. No		s Decedent of es, specify Cu Yes ZE N	Hispanic Origi ban, Mexican, Specify:	in? (Specify Yo Puerto Rican,	es or No- etc.)		Rece - American Indian, Bleck, White, etc. cify: ack	
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900	Daniel Glascoe					Carri	e Mou:	zon			
-	19a. Informant's Name/Relationshi	ip (Type, Print)	19	b. Mailing	Address (Stre	et and Number	or Rural Rout	e Number,	City or Town,	State, Zip C	ode)
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	20a. Melhod of Disposition			of Dispositi	on (Name of		Date	9 2	Oc. Location -	City or Town	7, Stale
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	snock, or heart tailure. List o	nly one cause on each l	ne.								nterval Between Inset and Deeth
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	diseese or condition resulting in death)	a. Cere	Due to (or as e		recident					1	aays
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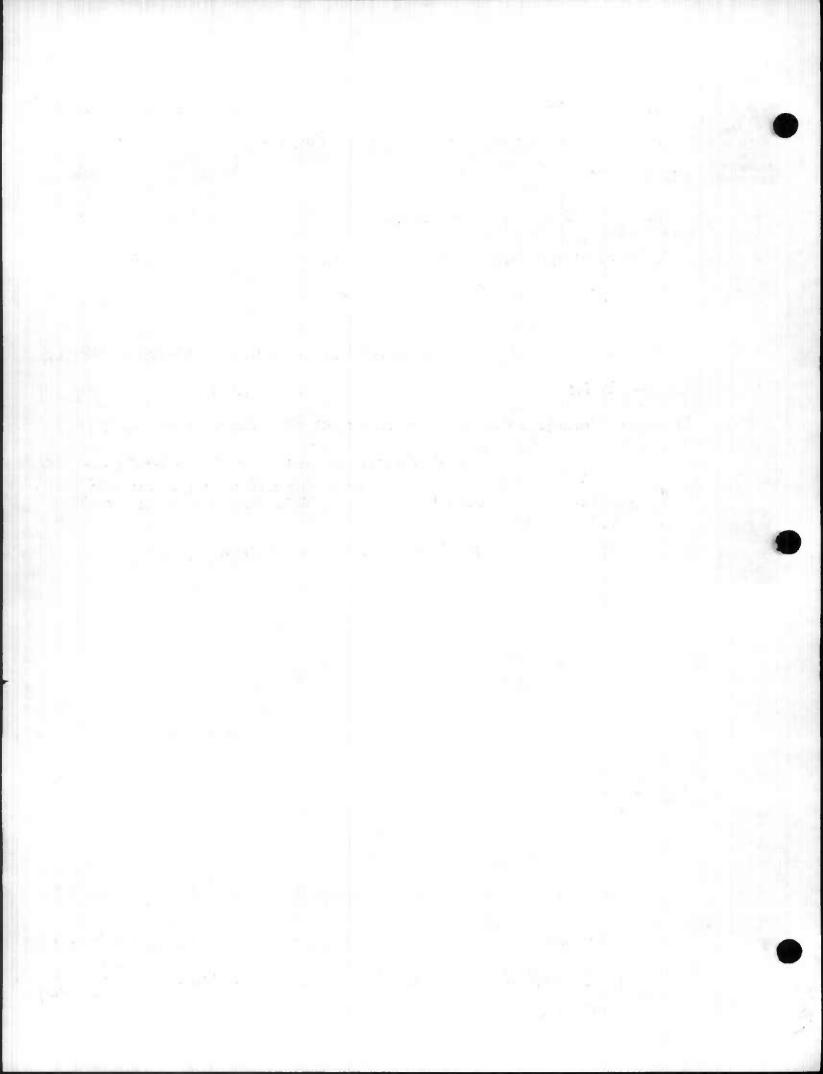
SCOR STORY

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month **Physician** 2:30 Am KYIER 99 08 04 /Medical 4a. Facility Name (If not institution, give straet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE IN UNDER 24 Hrs. 8 ELDERCARE NIA ATONSVILLE TR. NURSING 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 12 M 20 F Days Hours 215-16-5379 76 Yrs Director Usual Rasidence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at BALTIMORE 1 Yes 2 No NIA Funeral Director 10e, Street and Number 10f. Zip Code 10g. Cifizen of What Country? with ŏ KOAD 238 WOODINGTON 21229 N. items: 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Biack, Whita, etc. filed within 72 hours after 1 Never Married 2 Married 2 No 21215-0020 ŏ If Yes, Give Year or Dates: 1 Yes 2 No Specify: by BLACK Specify: 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) Colleges (1-4or 5+) 12 TH GRADE ASSEMBLY LINE WORKER NA GENERA Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be DEWEY KYLER MARIE 19ą. Informent's Name/Relationship (Type, 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 Department of Health a Important: If Item 27 Is any injury or other tra DAUGHTER BAUTO KIMBERU-TANNER LANGFORD MD. 20b. Piace of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 8-10-99 KANDAUSTOWN MO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Milluice Licensee 22. Name and Address of F VAUGHN C. GREENE FUNERAL SERVICE 23a. Pert 1. Enter the dish use, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. BALTO. MD. Approximate Interval Between Onset and Death **Physician** astatic Car cinima /Medical Immediate Ceuse (Finei disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or as a consequence of) is signed by the at Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? this certificate hes or Attending Physician: Be 25. Was case referred to medical 26. Piace of Death (Check only one) examinar? ^oL 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residanca 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA Certification: 27. Manner of Death 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a To the Funeral D edicai 29a. Certifier Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as stated.

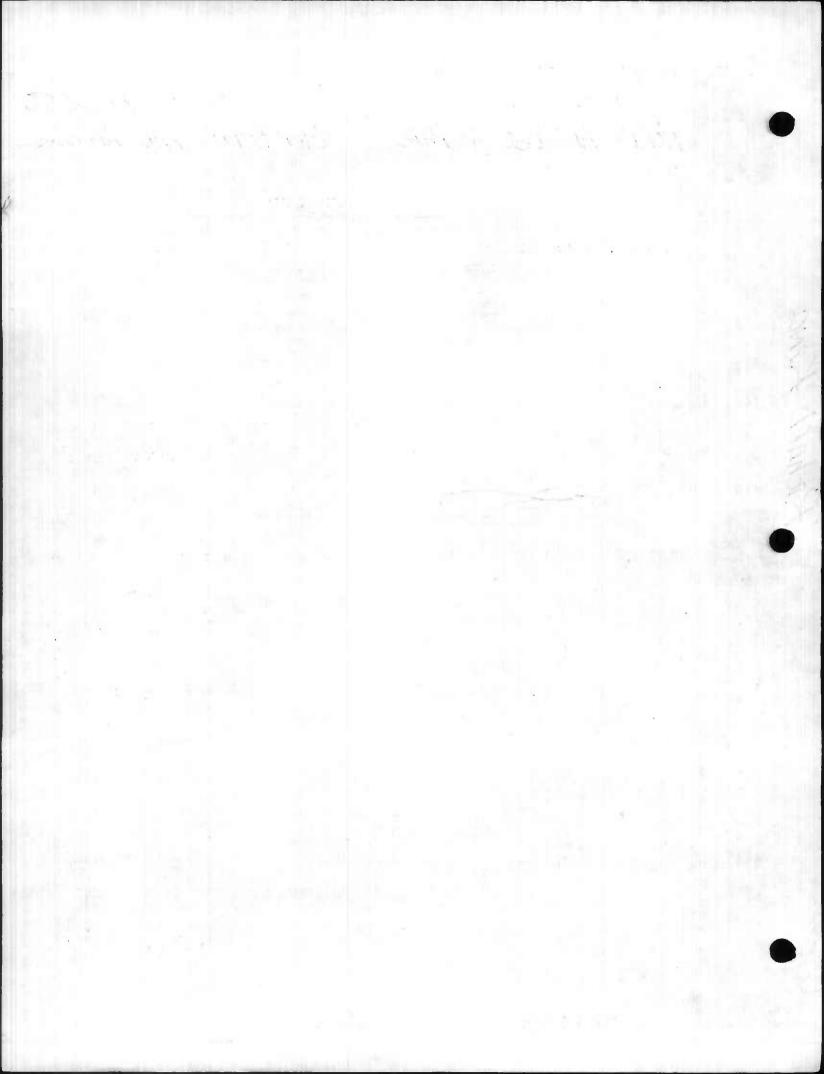
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the ceuse(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. Licansa numbar 29d. Data signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Suite 308 FZI N. EU taw S+ Ballin Sabapathe 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 0 1999 Registrar

DHMH 16 Rav 6/95



AMEND ITEMS:	#10C PER F.H. 23 PART	State of Maryland I PER MD G774 8-10		f Death	Reg. No.	25018	
Physician	1. Decedent's Name (First, Middle, Las			2	Date of Death	3. Tima of Death	
/Medical		King, Sr.			8 /	99 2050	
Examiner Funeral Director	215-30-3155	DEC HOSPI	st birthday) If Under 1 Yau Yrs. Months Day	s Hours Min.	Lote of Birth (Month, Day, Year) Feb. 20, 1934	Birthplaca (State or Foreign Country)	
p .	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location DALT	THOOF CITY		10d. Inside City Limits	
fanyla ad et	MD N/A		DALI	IMORE CITY anover Stre e	et	Yes 2□No	
ith with the Maryla 23a or 28a-f show ust be notified at rai Director	10e. Street and Number 1724 South Hanove	er Street	10f. Zip Code	21230		What Country? ced States	
ors after dear at, or hems Examiner ms	11. Marital Status 1 Never Married 2 Married 3 Widowed MXDivorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes ∑₹∑ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Speci uban, Mexican, Puerto Ri o Specify:		ce - Amarican Indian, ack, White, etc. fy: White	
L X I X 13-UUXU ed within 72 hours at ygiens, "natural", or or than "natural", or or, the Medical Exam Completed by it	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti Longshorem	ne during most of working red)		Business/industry Shipping	
Marryland & 32 should be filled v h and Mental Hygie f is marriad other traumatic event, the To Be Co	17. Father's Name (First, Middle, Last) Edward R. King	0	DONGSHOT CH		First, Middle, Maiden Suma: Jupitz		
Mary nd 2 shou lith and M 27 is mar r traumat	19a. Informant's Name/Relationship (T Christina L. King				Route Number, City or Town		
L Pages 1 a mant of Hea tant: If Nem jury or othe	20a. Method of Disposition **Description 1	Removal from State	nce of Disposition (Name of metery, crematory or other p r Hill Cemetery	August 11		- City or Town, State	
Balli permit. Departments imports any inju	21. Signature of Funeral Service Licens	Victor P. Doo		L. Stevens	Funeral Home		
Minote be executed filters be executed for the burishing physician and set the burishing filters from the fi	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or a	as a consequence of): as a consequence of):	Pumon	TERMINAL .	Onset and Death Co uses	
P.O. BOX 687 et the death certificate is 1 by the ettending physicatched for use as the Physician/Medici		d				1	
P.O. Het the d by the Setaches	Part II. Other significant conditions co	of the state of th	ling In the underlying cause	given in Part I.	23b. Did tobacco use co	ontribute to the cause of death? 3 ☐ Probably 4 ☐ Unknow.	
aw requ	COPD	<i>U</i>		4	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?	
Page h	Old Sho	ke			1 □ Yas 2 No	1 ☐ Yes 2 ☐ No	
redor. The rector, page Co	25. Was case referred to medical axaminer?	11		26. Placa of Death (Check only one)		
	1 ☐ Yes 2 🕅 No 27. Manner of Death		H/Outpatient 3LI DOA		5 Residence 6 Ot		
MVISION or Attending ther death. Hector: After in by the fune rtification	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year)	28b. Time of linjury M 28c. In V 1 1 28c. In V 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital of within 24 hours a To the Funeral Discompletely filled is Medical Ce		sician: To the best of my knowliner: On the basis of examination and manner stated.					
To the within To the comp	29b. Signature and title of certifier	7 MD		-4052L	Angus	ed (Month, Day, Year) KS, (999	
	30. Name and address of person who o	•	Man Bur	J Odkur mey MD	21061	Suite 205	
State Registrar	31. Date filled (Month, Day, Year) ALIG 10 10	32. Registrar's Signatu	A loca	1.1:			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Agnes M. Luongo August 8 1999 10:40am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 207 S. Grundy Street Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Hazelton, Pa. 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 □ M 2 1 F Yrs 171-01-5493 81 5-5-1918 Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 1X Yes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? Grundy Street 207 S. 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried White 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 □ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Polumbo Dora Polidore 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON Luongo 206 Mulberry Lane, Baltimore, Maryland 21220 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 8/11/99 Baltimore, Maryland Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of FacilityJoseph N. Zannino Jr. Funeral Hm. Maria II. Zanne 263 S. Conkling St., Baltimore, Maryland 21224 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert II. Other algolificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 Yes 2 No 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 20-No 25. Was case referred to modical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner

Examiner

þ

1 Waturel

2 Accident

4 Homicide

29b. Signature and title of

31. Date filed (Month

3 Suicide

29a. Certifier (Check only one)

permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other trainmatic event

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

Herra:

8

Director

Funeral

à

Completed

Be

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

physician and s the burial-transit that the death certificate be executed Box 68760 Physician/Medical 88 signed by the at 5 be detached for P.O. Division of Vitai Records. The law requires Completed page 2 s nas. certificate Be

a.Hgapital or Attending Physician: 24 hours after death. • Funeral Director: After this certific funeral director, 6 To the Hospital or A Within 24 hours after To the Funeral Dire-completely filled in b

Medical Certification: To

State Registrar Name and address of person who comple nant

5 Pending

2 ☐ Medical Exa

investigation

6 Could not be

cause of death (Item 23a) (Type, Print)

W

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c License numbe

1 Yes 2 No

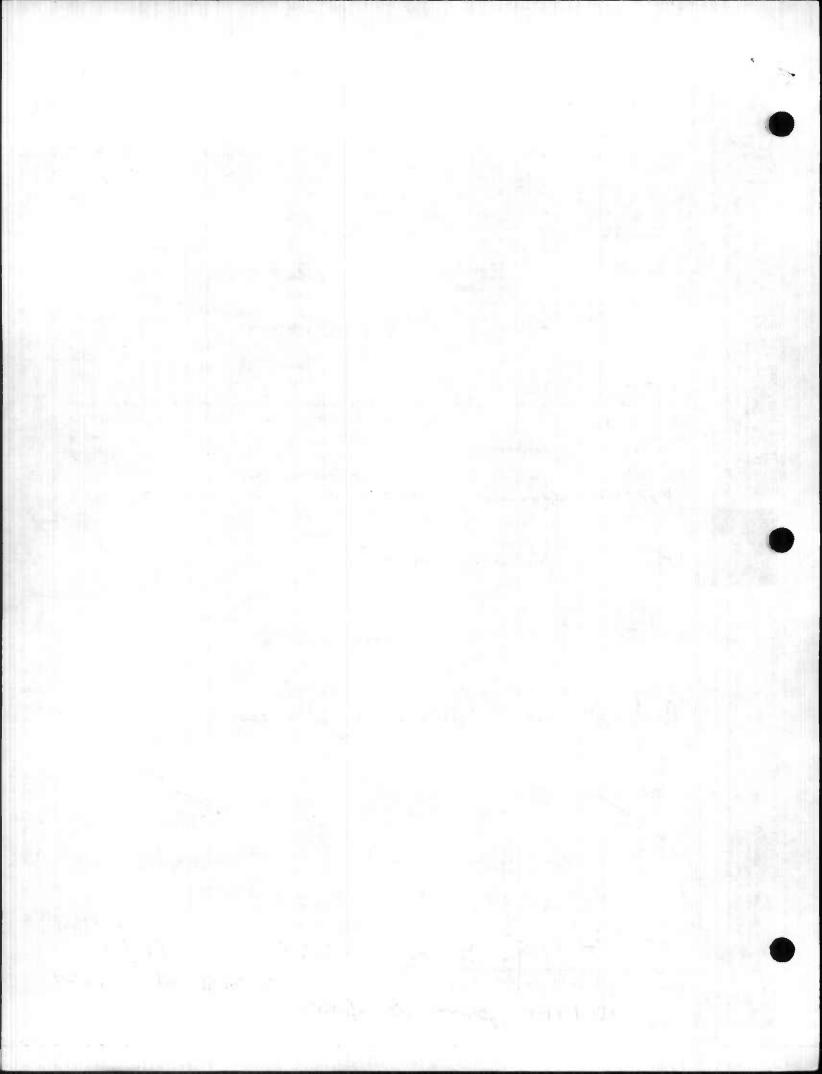
29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

32. Registrer's Signeture 1 AUG 0 1999

28b. Time of

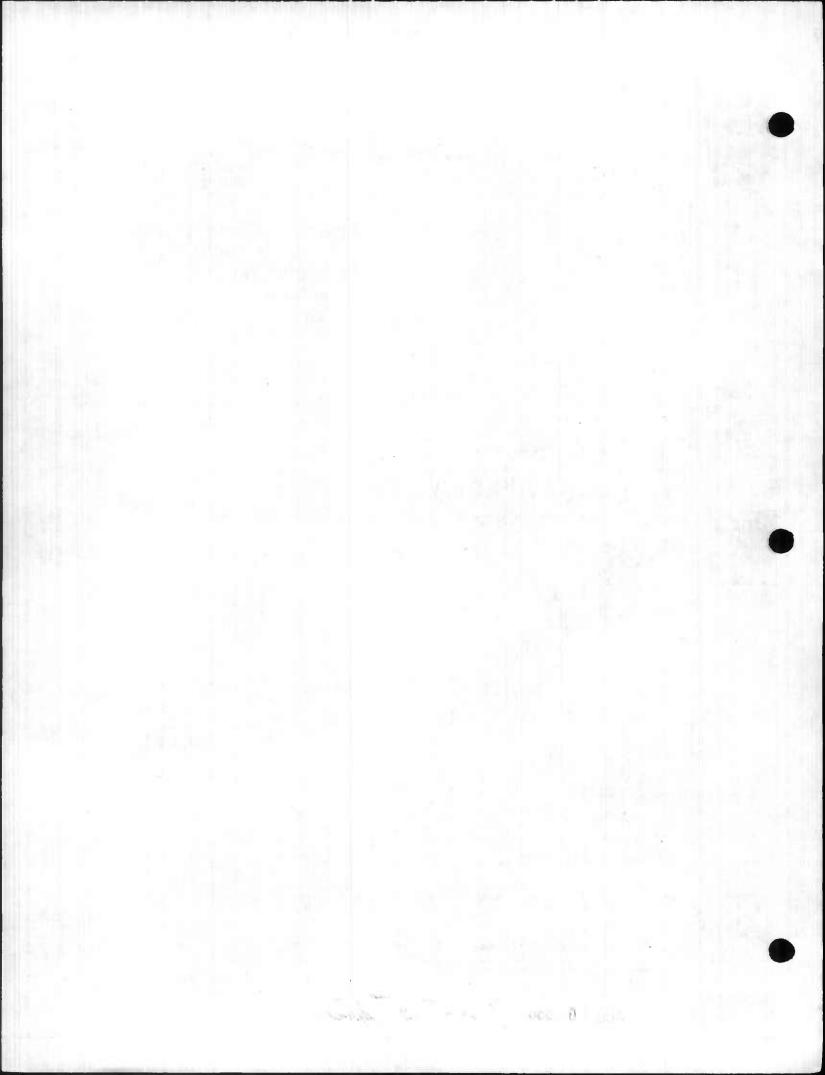
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



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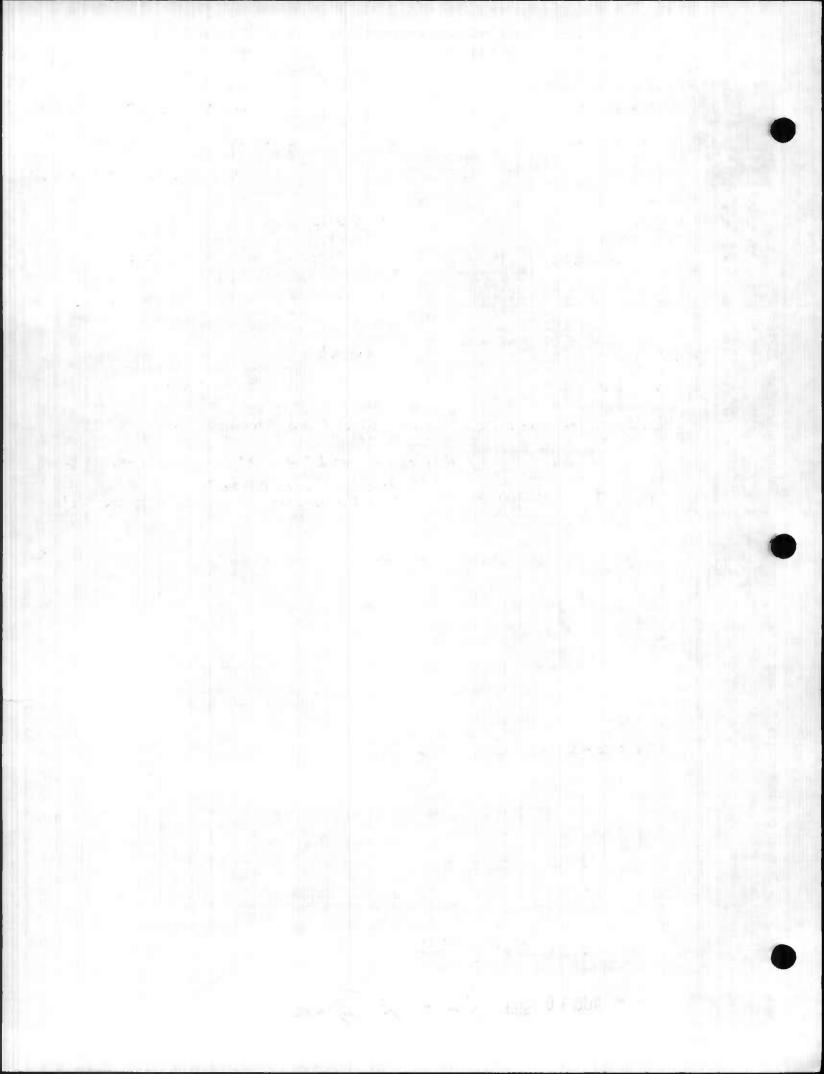
State of Maryland / Department of Health and Mental Hygiene 9 25020

				Ce	rtificate c	of Death		Reg. I	No.			
		1. Decedent'a Name (First, Middle, Las	1)			7770		te of Death	Day	Year	3. Time of Death	
	Physician /Medical	Gordon Henry	Little							999	5:05 PM	1
	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, To	wn, or Location	of Death	4c. County of	of Death		
		Mariner Health o	of Forest Hill	1		Fore	est Hill		Harf	ord		
	Funeral	Sociel Security Number 6. Security Number		. last birthday)	If Under 1 Ye Months Dar			te of Birth onth, Day, Ye	ar)	9. Birthpi	ace (State or Forei	gn
	Director		OM 20F 77	Yrs.				14, 1			York	
	D B	Usuel Residence of Decedent 10a, Stete 10b, County	10c C	ity. Town or Lo	ncation					11	0d. Inside City Limit	t a
	aho aho										1 ☐ Yes 🏋 ☐ N	
	vith the Mar t or 28a-f al be notified Director	MD Harfor	d J F	orest	HIII 10f. Zip Cod	la		100	Citizen of W	that Coun	trv?	
	With With	1610 D Rebecc	a Court			1050-2	2015			nat oour	uy:	
	within 72 hours after death with the Manyland ene. than "natural", or items 23s or 28s-f show he Medical Esserieur must be notified at ampleted by Funeral Director	11. Merital Status	12. Was Decedent Ever in U	U.S. 13					USA 14. Rece	- Americ	an Indien,	
	ter d	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	0,0.	If Yes, specify C	uban, Mexican	igin? (Specify Ye n, Puerto Rican,	etc.)		k, White,		
020	by F		If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐X	No Specify:			Specify:	Wh:	ite	
0	natural',			16a. Dece	dent's Usual Oc	cupation		16b	. Kind of Bus	siness/Inc	lustry	
215	ed within 72 ho ygiene. er than "naturn ft, fre Medeall	(Specify only highest grad Elementary/Secondary (0-12)		completed) (Give kind of work done during most of life. DO NOT use retired)								
21		12	Salesman						Insur	ance	2	
nd	严重看 5					18. Mothe	er's Name (First,	me (First, Middle, Maiden Surname)				
yla	should be ind Mental ind Mental or umertic ave	Gordon H.	Little				Bridge	ette l	Hoag			
Maryland 21215-0020	OI TO THE	19a. Informant's Name/Relationship (7		1			er or Rural Route		-			
	Health Health Jother tr	Dorothy Little/								_	21050	
Ore		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	osition (Name of matory or other	place)	Date		. Location - (City or To	wn, State	
tim	ment: lant:	4 Donetion 5 Other (Specify	M				08/09/		altim			
Baltimore,	permit. Pages Department of Important: If i any Injury or RDGS.	21. Signeture of Funeral Service Licens	mc mal	D E	2. Name and Ad remati	on Sociality	ciety o	of Man	rylan	d, :	Inc.	
	005 e a	Dawn F. McDo		2	99 Fre	derick	k Rd. 1	Baltir	more,	MD	21228	
		23a. Part1. Enter the disease, or comp shock, or heart tailure. List only of	dications that coused the dea one cause on each line.	th. Do not en	ter the mode of	dying, such as	cardiac or respi	ratory arrest,		i	Approximate Interval Between Onset and Death	
X.	Physician /Medical	In the Country of the	1=0							1		
38	Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	a. 77>7	1 KATT	ON T	NEUN	IONIA				3 DAYS.	
	5		Due to ((or as a conse	quence of):							
	axecuted in and isl-transit		b							1		
,	cate be axecuted physician and sthe buriel-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to (or es a conse	quence or):					[
68760,	ficate be physicia as the bur edical	Cause (Disease or injury that initiated events	C. Due to /	or as a consec	mence off.							
	+	resulting in death) Last	200 (0 (,0000 0.,.							
Box	attending for use a		d	_								
	es that the death ce gned by the attendi be detached for use by Physician/	Pert II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying cause	given in Part I	I. 2	3b. Did tobac	cco use con	tribute to	the cause of deat	h?
P.0	by the tache	11711	11-2/2 71			-		1 Yee	2 No	3 Prol	pably 4 Unkno	nwc
	res that the designed by the a to detached for by Physic	ALZHEII	MERS DI	55715	t							
of Vital Records,	been sign should be						24	la. Was an ai		av	ere autopsy finding allable prior to	5
900	lew re as be 2 sh										mpletion of cause death?	
æ	0 F 5 F						11.00	1 Yes	2ENo	10	Yes 2□No	
ita	delan: The certificate rector, per	25. Was case referred to medical				26. Place	e of Death (Che	ck only one)				
>	2 00	examiner?	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatie	nt 3 DOA	Other: 40 Nu	ursing Home 5	Residence	e 6 □Othe	er (Specif	y)	
	After this funeral funeral	27. Manner of Death 1/50 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. i	njury at Work?	28d. D	escribe how i	njury occurr	ed		
0	Attending in death. sctor: After by the fune fune fill cation	2 Accident investigation			M	1 Yes 2	No					
Division	tal or Attanding P rs after death. al Director: After t led in by the funer Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, ferm, st	reet, factory, offi	ice	28f. Lo	cation (Streetly or Town, S	t and Numbe tate)	er or Rura	Route Number,	
	Tal Dirth											
	To the Hospital or Attending Phi- milhin 24 hours after death. To the Function District After the completely filled in by the funeral Medical Certification: 1	(Check only 2 Medical Exam	reician: To the best of my kn Iner: On the basis of examin									
	Med	29b. Signeture end title of certifier	and manner stated.		29c 1 ic	ense number		29d	Dete signed	(Month	Day, Year)	
	이 등 이 이 이 이 이 이 이 이 이 이 이 이 이 이 이 이 이 이		Qualion	6 W	-	2800	96				1,1999.	
	11/						-					
	000	30. Neme and address of person who co	completed cause of death (Ite	m 23a) (Type,	125	N, M	A-IN S	7. 752	EZ- 111	P, M	10 2001	+
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	Registrar	AUG 1 0 19	99 J. wa		spor	les						



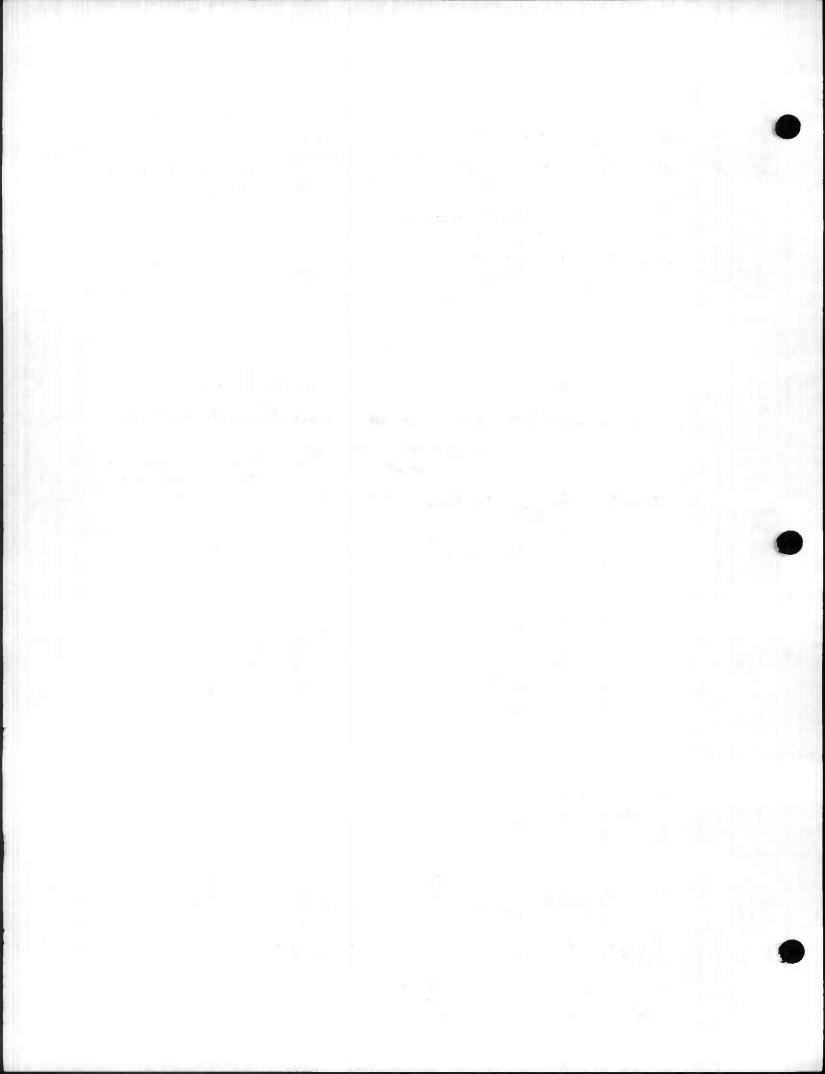
State of Maryland / Department of Health and Mental Hygiene 0 2502

		ecedent's Nem	e (First, Middle, La	ist)					2	Dete of Dea Month		Year	3. Time of D	eath	
Physician /Medical		Fanni	e Maie	Lemmo	ns				A	ugust	7, 1	999	1:37	AM	
Examiner	4a I	Fecility Name (I	f not institution, giv	e street and nun	nber)			4b. City, To	wn, or Loca	tion of Deeth	4c. County	of Death			
		1221 Qu	antril Wo	ay				Ва	ultimo	re		N/A	4		
uneral		ocial Security N		Sex 1□M 2X F		. last birthday)	Months Day		24 Hrs. 8 Min.	Date of Birth (Month, Day	Year)	9. Birthp	iaca (State or F	Foreig	
irector	-	42-01-0	418	1 M 230 F	81	Yrs.	INIONALIO DAI		1	Dec. 18	18,1917 North Carolin				
8		at Residence of . Stete	Decadent 10b. County		10c C	ity, Town or Lo	ocation					1	0d. Inside City	1 imit	
aho PC	1100				100. 0	ity, town of Le				1. ☑ Yes 2□					
Ser de la constante de la cons	MC	ryland	N/A				Baltimo		,		10g. Citizen of What Country?				
2 2	108	. Street and Nur					10f. Zip Code								
eral	1		ntril Way		dant Ever in I	16 12		1205	ala? (Cassi	the Von or No		S. A.			
al', or items 23s or 28s-f show Examiner must be notified at the Funeral Director	11.	Marital Status	led 2 Merried	12. Was Dece Armed For 1 Yes	ces?	J,S. 13.	Was Decedent of If Yes, specify C	uban, Mexican	n, Puerto Ri	can, etc.)	Bia	ck, White,			
r, or		3 Widowed		If Yes, Give	9		1□ Yes 2ÅN	lo Specify:			Specify	wh	ite		
re than natural, of			15. Decedent's E	1		16a. Dece	dent's Usual Occ	cupation			16b. Kind of Br				
fed for	-	- ' '	eify only highest gre	ade completed)	4 4 3	(Give	dent's Usual Occ kind of work do DO NOT use ret	ne during mosi ired)	t of working	,					
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d other than "nature event, the Moural Be Completed	17.		(First, Middle, Last)				18. Mothe	er's Name (First, Middle,	Malden Suman	10)			
marked other than matic event, the M	C	romye F	aw						Eliza	Bumga	rner				
le mar		. Informant's Na	ame/Relationship (Type, Print)								State, Zip	Code)		
If item 27 is marke or other treumatic To	Po	zula A.	Gibson (Daughte	7)	1221	Quantri	l Way.	Balt	imore.	Marula	nd 21	205		
E do		. Method of Disp	position		20b.	Place of Dispo	osition (Name of matory or other p	olace)			20c. Location -				
TY O			☐ Cremation 3 ☐ 5 ☐ Other (Specif		state			•	8/	10/99	1/99 Baltimore, Maryland				
Important: If item 27 any injury or other tr phcs.	21.		nerel Service Lice	•								,,,,,	noo cy court	101	
any is		171.	A la Ca	Jack	2			Address of Facility 12k Funeral Home Inc. 12ehms Lane, Baltimore, Maryland 21213							
-	238	a. Part1. Enter the	he diseave, or com rt failure. List only	nolications that ca	used the dea	th. Do not en	551 Brei	tving, such as	cardiac or	respiratory arr	rest.	icana	Approximate		
rsician		shock, or hea	rt failure. List only	one cause on ea	ach line.									nen	
ledical													Interval Betwee Onset and De		
legical		mediate Cause (c n								1	Onset and De	ath	
aminer	dis	mediate Cause (ease or conditio ulting in death)		a. 59	jeame	ors ce	el CA							ath	
aminer	discres	ease or conditio		a. 59	jeame		el CA						Onset and De	ath	
aminer	dist	ease or condition ulting in death)	in .	a	Due to (Or es a consec	QL CA						Onset and De	ath	
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State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (First, Middle, Las	*					2. Date of De			Ime of Deet	
Physicia: /Medica	_	William F. Lac	key					August	8. 1999	Year 7	:30 PM	
Examine		4a. Facility Name (If not institution, give 2901 Boston Stree	4b. City, Town, or Baltimor	Location of Deatl	4c. County		.50_11					
Funeral Director		5. Social Security Number 6. S 231–28–0072 1		e (In yrs. lest t 71	Yrs. If Und Month	der 1 Year ns Deys	Hours Min	8. Date of Bir (Month, Da June I	9, 1928	9. Birthplece (S Country). Virgin	State or For	
>	- }-	Usual Residence of Decedent 10a. State 10b. County		10. Oh. Ta								
eho.					wn or Location				10d. Inside City Limi 1 Nes 2 □ N			
288-1	Director	MD		Balti							2169 22	
0.8		10e. Street end Number			101.	Zip Code			10g. Citizen of W			
in 23	era	2901 Boston Stre	et Apt 208		13 Was Do	212		nacihi Vas as Na	U.S.A.	- American Inc	lien	
el, or items 23s or 28s-f show Explainer must be notified at	by Funeral	11. Maritel Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Armed Forces? 1 Yes, Give Year or Dates:			as Decedent of Hispenic Origin? (Specify Yes or News, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No Specify:			Black Specify:	k, White, etc.	neri,	
it of Health end Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Evaluation must be not that as	Completed	15. Decadent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5		a. Decedent's U (Give kind of life. DO NO?	sual Occup work done Tuse retire	pation during most of wo d)	rking	16b. Kind of Bu			
or th	^ဂ ္ဂ		4	A	Art Dire	ctor						
d oth	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Neme (First, Middle, Meiden Sumeme) Frances T. Roderick					
Merke	9	Robert M. LaCKEY				_						
		19e. Informent's Neme/Relationship (Type, Print) Dr. Patricia J. Lackey (Wife) 19b. Mailing Address (Street end Number or 2901 Boston Street							Apt. 208, Baltimore, MD 21			
Department of Health Important: If Item 27 eny Injury or other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specify		Baltin	of Disposition (fitery, crematory of Disposition (fitery, crematory of Disposition (fitery, crematory)	hing!		Date 3/9/99				
Department Important: If eny Injury o once.		21. Signature of Funerel Servica Lican	1500	UT(ematory 22. Name	and Addre	ess of Facility W	itzke Fi	ineral Ho	omes. I	nc.	
8 . 8		PRONT Y	n		1630	Edmo	ondson Av	enue, Ca	tonsvil	le, MD	21228	
ysician		23a. Pert1. Enter the disease, or com- shock, or heart failure. List only	One cause on each in	10.							oximete	
Medical kaminer	- e	Immediate Cause (Final disease or condition resulting in death)	. Metas	tatic		leno	ca of			Onse	val Between of and Deat	
kaminer pue u jel-treusit	Examiner		b	Latic Due to (or as	ad	leno				Onse	val Between of and Deat	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Paul Jefferson Martin **Physician** Aug. 6, 1999 1:00 PM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 858 Jaydee Avenue Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) May 2, 1920 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Monfhs Days ₩ M 2 F Yrs. 233-28-1702 79 Director Usual Residence of Decedent or 28a-f show be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nems 23s 858 Jaydee Avenue 21222 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, White, etc. 11 Merital Status hours after 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☐ KNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Milling Machine Operator Manufacturing 8 Years 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) is marked of Pages 1 and 2 should be Stella Nunley Otto Watson Martin 2 19e. fnforment's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Important: If Isen 27 is any injury or other trea 858 Jaydee Avenue Dundalk, Maryland Isabelle Martin Health I Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c Location - City or Town State 20e. Method of Disposition Date Department of 1 ☐ Burial 2XDCremation 3 ☐ Ramoval from Stata Hilltop Service Corp. 8/10/1999 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. DRAW Dundalk, Maryland 7922 Wise Ave. 23a. Part / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximete fnterval Between Onset and Death **Physician** /Medical immediate Cause (Finel · PARKINSONS DISCUSE disease or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner that the death certificate be executed Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of). 98 for use as P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy page 2 s 1 Yes 2 No 1 Yes 20 No certificate Division of Vital or Attending Physician: after death. director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa Statement 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Dete of fnjury (Month, Day Year) 27. Menner of Daeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after Funeral Directions 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29e. Certifier completely (Check only To the Within 2 29b. Signatura and fitla of certifier ew 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 6 Belgin 91 Agran, MD 21236 72 GUIDE owe

State Registrar 31. Date filed (Month, Day, Year)

AUG 10

DHMH 16 Ray 6/95

32. Registrer's Signeture



			State of Ma	aryland / I	Departm Certific		lealth and I Death	Mental Hy	Reg. No.	250	24				
	1. Decedent's Ner	me (First, Middle, La	st)					2. Deta of De Month			Time of Death				
Physician /Medical	NIKIT	AS . MA	RKOS.	MAR	CUR:	I		AUGUS	Day 19	Yaer 199	MAGO .				
Examiner			a street end number)				4b. City, Town, or	Location of Deel	h 4c. County	of Deeth					
	HARBO	R HOJP	ITAL (ENTE			BALTI		N/A						
ral tor	5. Sociel Security 216-36-3	3076	ax 7. Ag X M 2□ F 60	e (In yrs. lest bii	Yrs. If U	hs Deys	If Under 24 Hrs Hours Min.	8. Dete of Bi	th 1939	9. Birthplaca (Country) 0h10	(Stete or Foreign				
	Usuel Residence	ot Decedent		10c. City, Tow	m or Location					10d In	side City Limits				
by Funeral Director	MD	N/A		Baltin							Yes 2 No				
Dire	10e. Street and No		- 4			Zip Coda			10g. Citizen of						
<u>a</u>	1559 MII	liam Stre	_			230			United:						
nue	11. Marital Status	V	12. Was Decedent Armed Forces?	100	13. Was D	ecedent of I specify Cub	Hispanic Origin? (S ean, Mexicen, Puer	pecify Yes or No o Ricen, etc.)	D- 14. Rec Biad	e - American tro ck, White, etc.	dian,				
by		rried 2 Married 4 Divorced	1X Yes 2 I	Peacetime	1□ Ya	s 2 No	Specify:		Specify	. White					
eee	(Spe	15. Decedent's Ed		16e	Decedent's (Jsuel Occup	pation during most of wo id)	rkina	16b. Kind of B	usiness/Industry					
Completed	Elementary/Sec		College (1-4or 5	341					Tenania						
S			3		re Pro	tecti	on Engine			Insurance Heiden Sumeme)					
Be		(First, Middle, Last,								10)					
2	Markos M							dria Dro		Ct. 4. 7. 6					
		Neme/Relationship (NE Reinhol			_		Street, I				1230				
	Catherine Reinholdt/wife 1228 William Street, Baltimore, Maryland 21230 20e. Method of Disposition 120 Burial 2 Crametlon 3 Removel trom State 4 Donation 5 Other (Spacify) 20b. Plece of Disposition (Neme of competery, cremetory or other plece) Loudon Park Cemetery 08/11/99Baltimore, Maryland														
an al er	23a. Part Entar shock, or he immedieta Cause disease or conditi resulting in death	ert teilure. List only e (Finel ion	plications that causac one ceuse on each li	ne.	LCEL	L L				Inter	roximate vel Between et and Death				
-lue	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Cause (Disease (Diseas										+ Jeme				
dical Examiner										4	YEAR Y				
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y Physician/Me	Pert II. Other sign	mean conditions c	ontributing to death b	of Not resolding i	in the onderly	ing ceuse gr	verrii reitt.		Yes 2 No	3 Probably					
Completed by									s an eutopsy ormad?	aveileble	utopsy tindings e prior to tion of causa 17				
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Be (25. Wes cese rete examiner?	erred to medical					26. Plece of De	eth (Check only	one)						
To		No	Hospitel: 1 Inpatie	ent 2 ER/O	utpetient 3	DOA	her: 4 Nursing h	lome 5 ☐ Res	idence 6 Oth	ner (Specify)					
	27. Manner of Dec 1 Natural 2 Accident	eth 5 ☐ Pending investigation	28e. Dete ot Inju (Month, De		Time ot Injury M	28c. Inju Wo	ryet ork?]Yes 2 ☐ No	28d. Describe	Describe how Injury occurred						
nited in by the runara	3 Sulcide 4 Homicide	6 Could not be determined	200. Piece of inj	ury - At home, te c. (Specify)	erm, street, te	ctory, office			(Street end Numi own, Stete)	ber or Rural Rou	ite Number,				
edical C	29a. Certifier (Check only one)	Certifying Ph	ysician: To the best niner: On the basis of end menner st	t axaminetion ar	e, deeth occur nd/or investige	red et the ti	ime, date end plece opinion, deeth occ	e, end due to the urred et the time	ceuse(s) end m	enner es stated. and due to the	ceuse(s)				
Me	29b. Signature an	d title of certifier	N CHARL	-		29c. Licen	sa number		29d. Date signe	d (Month, Day,	Year)				

3001 · S. HANDVER ST 31. Dete tiled (Month, Day, Year) 32

MD BALTEMORE MD212LS

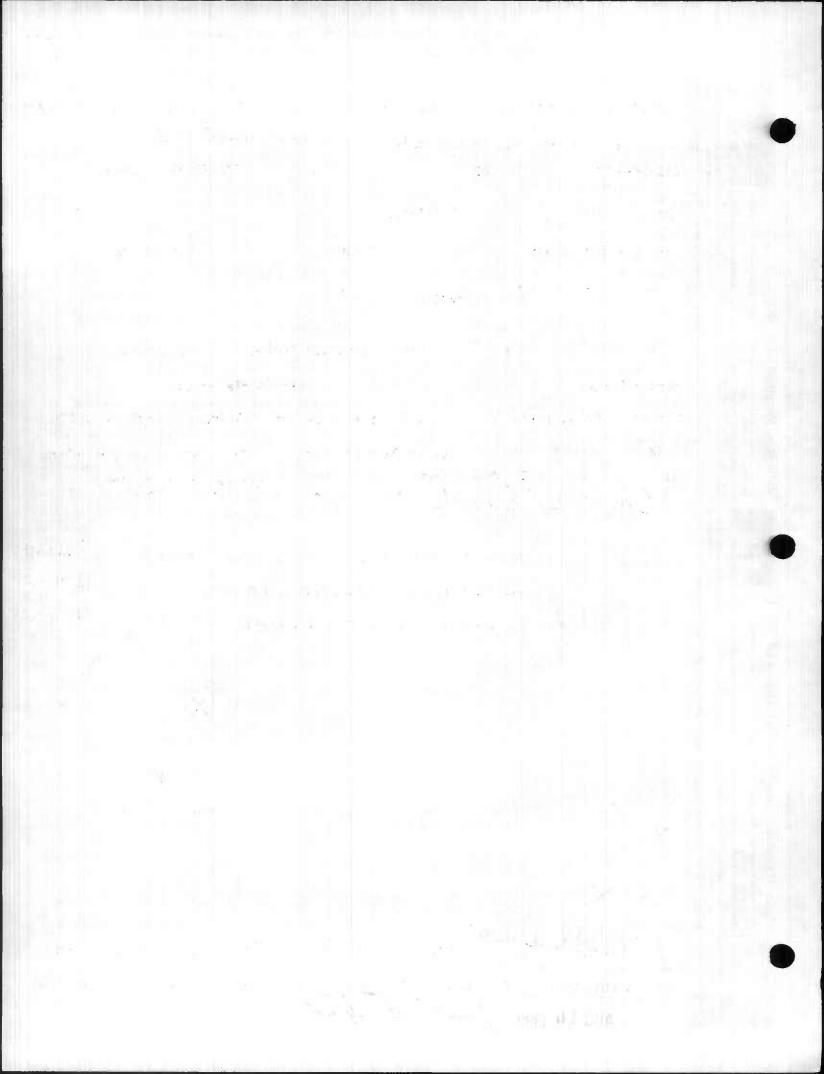
BP9A P12090

29d. Date signed (Month, Day, Year) 1999

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

AUG 10 1999

State Registrar



2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

souks

32. Registrar's Signeture

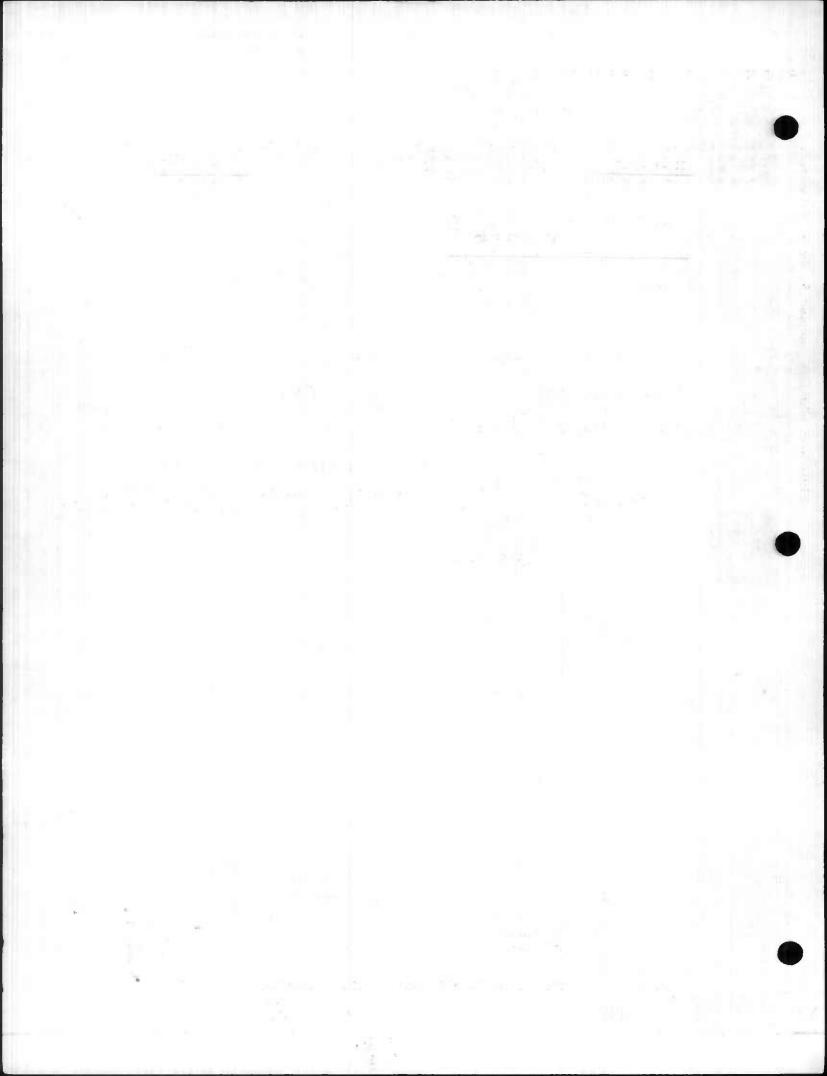
Registrar

State

DR. TARIQ MAHMOOD

AUG 1 0 1999

31. Dete filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 94945 /Medical 4c. County of Death 4b City Town or Location of Death Facility Name (If not institution, give street and number) Examiner 9 lens If Under 1 TO 100151 Social Security Number ord mor Jar Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In yrs. last birthdey) 9/Birthplace (State or Foreign **Funeral** 228 Months Deys -12-30 Hours 1 M 2 F Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Show Maryland 1 Yes 2 No Funeral Director nor 280-10f. Zip Code 10a. Street and Number 10g. Citizen of What Country? ò 0 0 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Herne American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐ Yes 2 Yes, Give 1 Never Married 2 Married 2 No 21215-0020 6 Specify: AFRICAN AMERICAN 1 Yes 2 No Specify: Completed by 3 N Widowed 4 □ Divorced Year or Dates: "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College, (1-4or 5+) 0 nit. Pages 1 and 2 should be filed artment of Health and Mental Hygis ortant: If Item 27 is marked other Injury or other trsumatic event, II Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 6 Informant's Name/Relationship (Type, Print) (NIECE) 21074 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code tam Stead rainia 20b. Piece of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location City or Town, State 1 Buriel 2 Cremetion 3 Removal from State Department of important: If any injury or 8 Memoria 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/License 22. Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart define. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 3475 Examine Physician/Medical Examiner he The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Box 68760, Due to (or as e consequence of) Division of Vital Records, P.O. Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part It. 23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 20 No 1 Yes 2 No or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital of To the Hospital within 24 hours a To the Funeral 5 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifie

State Registrar

31. Dete filed (Month, Day, Year) AUG 1 0 1999

29b. Signeture and title of certifier

50 Curre

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

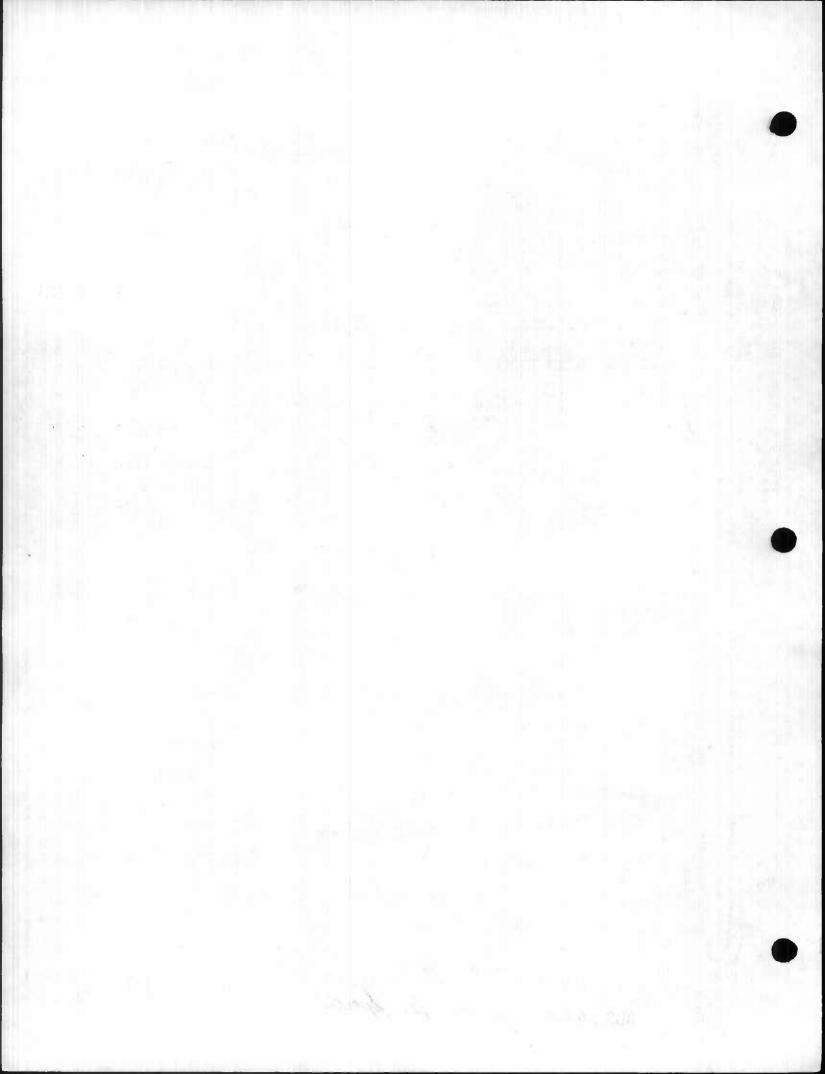
LAMESH SABBBBBBB SULTESOS 32. Registrar's Signature

GARAMOLEM D21201 821 N-EUTOWST.

29d. Date signed (Month, Day, Year)

29c. License number

D 50641



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death AMEND ITEM: 26 PER MD G774 8-10-99 WR. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month 640 Pm CLARA E MANN 99 8 6 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death PRINCE GEORGES MAGNOLIA NURSING CENTER GREENBELT If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In vrs. last birthday) If Undar 1 Yaar 9. Birthplaca (Stata or Foreign 8. Data of Birth (Month, Day, Year) 1 □ M 2 🛱 F Days Months Hours 98 020-07-8901 JUNE 29. 1901 MASSACHUSETTS Usual Residence of Dacedant 10d. fnslda City Limits 10a Stata 10b. County 10c. City. Town or Location MARYLAND ANNE ARUNDEL ELKRIDGE 1 Yas 2 No 10e. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? 8006 KEETON RD. 21075 UNITED STATES 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Orlgin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: WHITE 3 X Widowad 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Collega (1-4or 5+) Elemantary/Secondary (0-12) HOMEMAKER OWN HOME 12 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) DELPHINE CONNOVER OLIVER PLASSE 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informent's Neme/Reletionship (Type, Print) 8006 KEETON RD., ELKRIDGE, MARYLAND 21075 HELEN ROGERS / DAUGHTER 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burlal 2 □ Cramation 3 □ Ramoval from Stata AUG. 1999 RESURRECTION CEMETERY CLINTON, MARYLAND 4 Denetion 5 Other (Specify) 21. Signature of Funeral Service Libensee 22. Nama and Addrass of Facilit KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onsat and Daath Immadlata Cause (Final Acute cerebrovascular accident 2 days disaasa or conditio rasulting in daath) Due to (or es e consequence of). Atmal fibrillation ear 3 Dua to (or as a consaguance of): congestive heart failure ears Bua to (or as a consequence of) unknown etiology 4ears 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy complation of causa of death? 1 Yas 2 NO 1 TYes 2 No 25. Wes case rafarred to madical 26. Placa of Death (Check only ona)

Physician /Medical Examiner

attending physician end for use as the buriel-transit

signed by the a

should

certificate hes b The

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director,

From 24 hours Funeral Direction of the Front of the Front

To the Hospi Linin 24 hou Je the Funer completely fi

that the death certificate be executed

law requires

Box 68760.

o.

Division of Vital Records.

Examiner

Physician/Medical

P

Completed

Be

20

Certification:

edical

4 T Homicide

31. Data filed (Month, Day, Year)

29a, Certifier

Physician

/Medical

Examiner

Directo

Funeral

à

Completed

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours effer death with the Manyland and theath and Mantal Hygiene.
This if them 27 is marked other than "naturel", or items 23s or 28s-f show may or other trannation ovent, the Mandale Examiner may be notified at

Baltimore, Maryland 21215-0020

Saquantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Causa (Disaasa or Injury thet initieted avents rasulting in daath) Last

Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 2 1 No 1 Yas 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Dascribe how Injury occurred

1 Neturel 5 Pending investigation 2 Accidant 3 Suicida 6 Could not ba

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29b. Signarure and titla of certifiar Ve

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the causa(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. Licansa number

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) eter M Schissler MO 7500

Greenbelt, Md 20770

State Registrar

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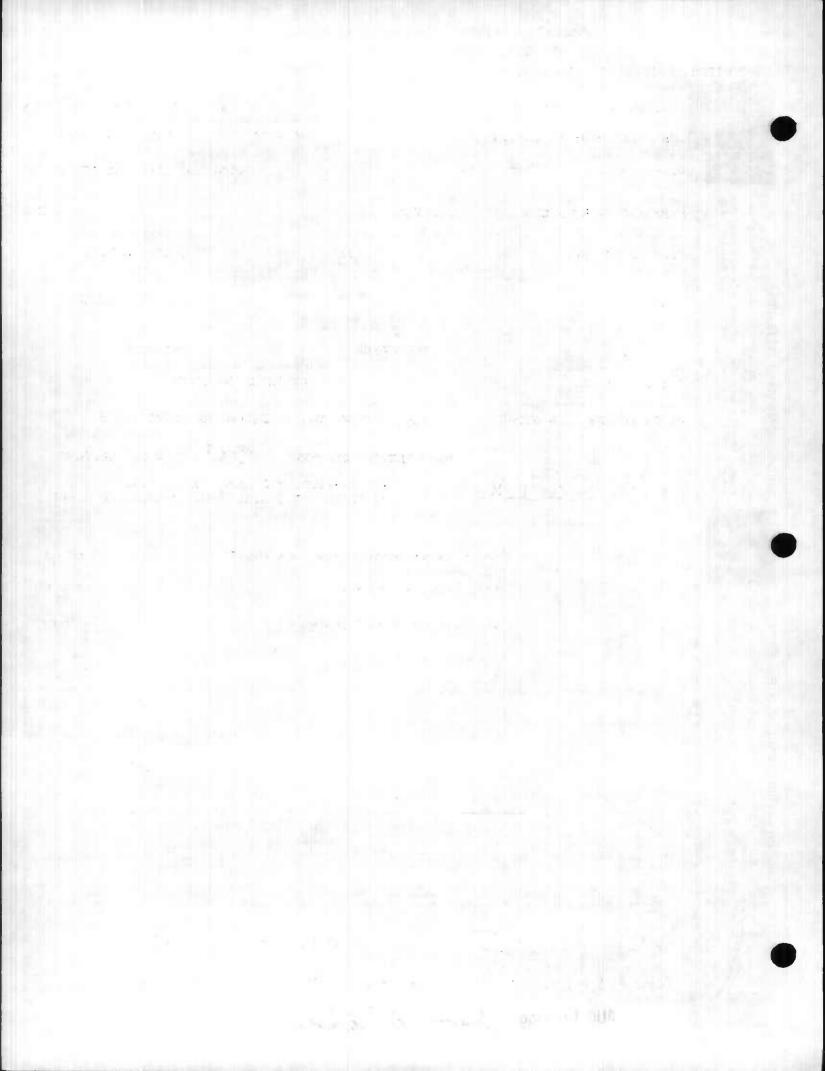


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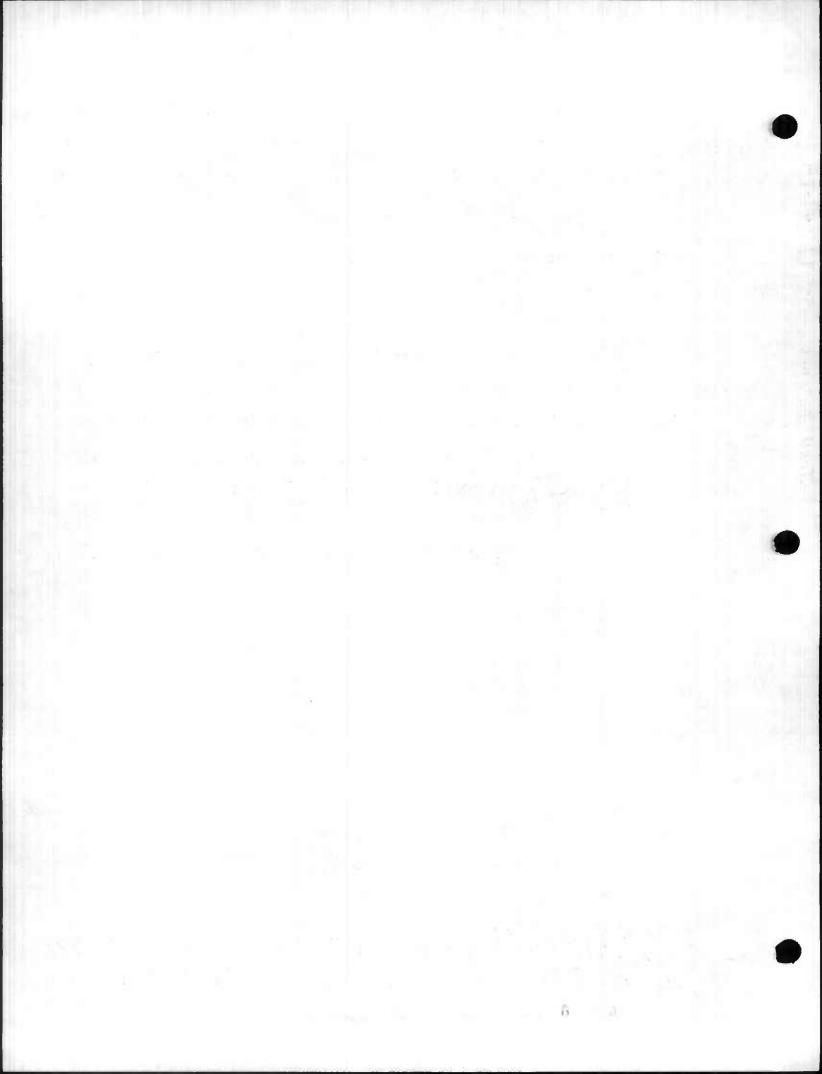
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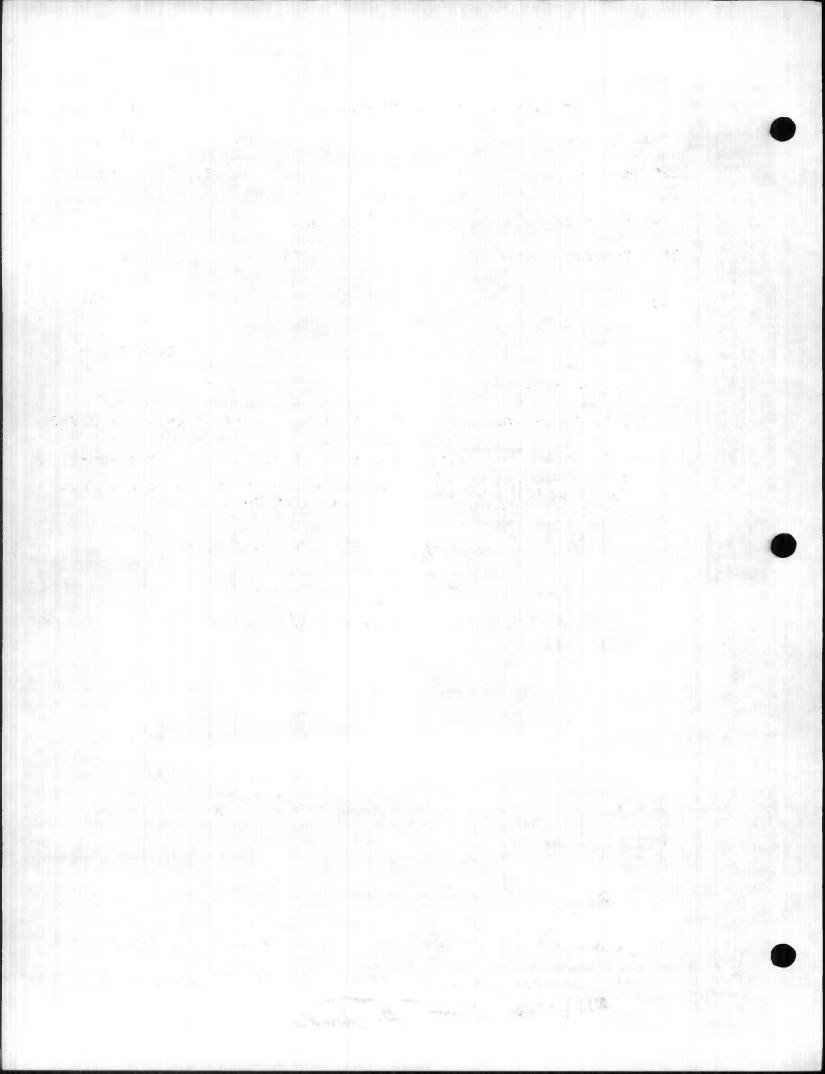
Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima ot Death Day Year Month **Physician** Christine Elizabeth McDougall 6, 1999 AUG 7:45pm /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7512 Knollwood Road Towson Baltimore Hours Min. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Vrs 220-14-2828 95 Director MAY 22, 1904 Bermuda Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location worle 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 7512 Knollwood Road 21286 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health end Mentel Hygiene. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White py 3€ Widowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Bookkeeper 12 Drug Store 7 is marked other traumatic event, I 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Ida Kyme Arthur Burgess 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 is other tra Sandra A. Sanidas/daughter 7512 Knollwood Road Towson, MD 21286 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method ot Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetlon 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) = 8 Metro Crematory, Inc. 8/7/99 Baltimore, MD 21. Signeture of un rai Service Licenses 22. Name end Address ot Fecility Jama.n Cremation Society of Maryland, awn F. McDonald 299 Frederick Road Bal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List *only* one ceuse on each line. 299 Frederick Road Baltimore, MD 21228 Approximete Interval Between Onset and Deeth **Physician** Heart failure onges tive /Medical Immediate Ceuse (Final disease or condition resulting in death) **Examiner** Examiner physician end the bunal-transit the death certificate be axecuted Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Vascular disease Thero schrotic Division of Vital Records, P.O. Box 68760, Physician/Medical ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed b by 24b. Were autopsy findings avellable prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? paga 2 has 1 Yes 2 No 1 Yes 2 No cartificata or Attending Physician: director Be 25. Wes cese reterred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 0 this funeral 28e. Dete of Injury (Month, Dey Year) 27. Magner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Neturel 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation aftar deat 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) filled in by 4 - Homicide Hospitai 24 hours 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completaly (Check only one) Within 2 29c. License number 29b. Signature end title ot certifier D52016 , M.D. 1999 30. Name end address of person who completed cause ot death (Item 23a) (Type, Print) 87. # 650, Baltimore, MD21218 33 rd WaieL 200 E. Jamara

32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death «Month 1430 **Physician** MOORE ossie /Medical 4b. City, Town, or Location of Death 4c. County of De 4a Facility Neme (If not institution, give street and number) Examiner Burnie Hrundel Hrunde HOSDITA. 8. Dete of Birth (Month, Day, Year) March 29, 1903 If Under 1 Year Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 25 F 218-30-452 96 Vrs Director North Carolina Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at TOLYes 2 No **Funeral Director** WASH, D.C. NONE WAShington 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code USA 20009 Florida 704 AVE N.W 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status should be filed within 72 hours after nd Mental Hygiene. marked other than "natural", or fter ☐ Yes 2 No Yes. Give 1 Never Merried 2 ☐ Merried Specify: Black 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Domestic MAID Name: Flossic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental NORA William MOORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23772 19a. Informant's Name/Reletionship (Type, Print) Important: If item 27 is any injury or other tra Harriet Lee - Granddaughter 13800 Courtland St. upper mar boro, mary land 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 5 1 Burial 2 ☐ Cremation 3 ☐ Removei from Stete 8/11/99 Department 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery SuitLand, Maryland 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee Robert B bound.

Chiny Funeral Service 2605 to Shirlington Road

23a. Pert1. Enter the disease, or complications that called the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. ARLINGTON, Va. Approximete Intervel Between Onset and Death **Physician** ESPANDADA LABORDA JANUSCA NOSCENER Immediete Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examine NCONTRALES MENTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ANDIONAKULAR physician s the buriel UTEROSCI Box 68760. that the death certificate be Physician/Medicai Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 4 By Inknown 1 Yes 2 No 3 Probably NITUENTE Records, à The law requires GESTIVE HEART PAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? edical Certification: To Be Completed INSUFFICIENC GNA 22 No 1 Yes 1 Yes of Vital 25. Was casa referred to medicat examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 3□ DOA this 28a. Dete of Injury (Month, Day Year) 28b. Time of injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Division Attending 5 Pending Investigation 1 Neturel
2 Accident a 24 hours after death.

Funeral Director: After detaily filled in by the fur 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 0 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29d. Date signed (Month, Day, Year) 29b Signature and title of certifies 29c. License number

State Registrar

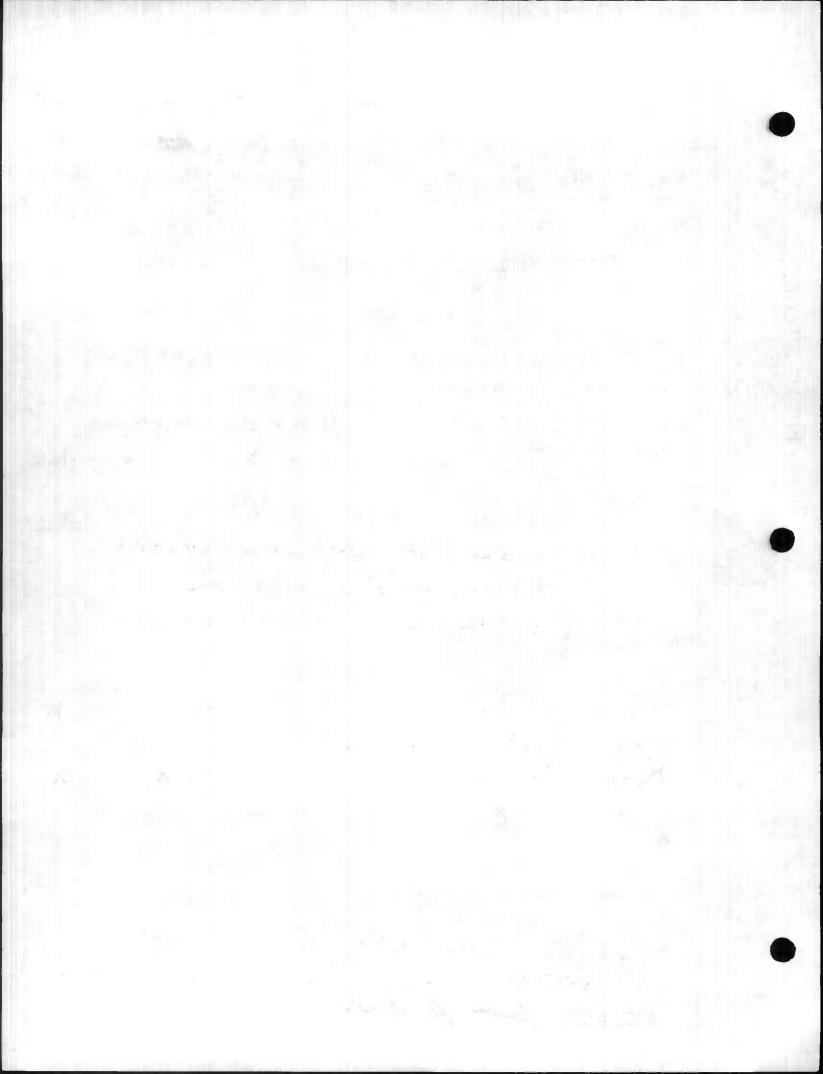
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31. Date filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrer's Signature

BOWSAMIN MALKIE



1. Decedent's Nama (First, Middle, Last)

Physician 1:30 P.M. CHARLES EDWARD McCARTHY 1999 August 4 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner SPULLE 1 6. Sex BAITIMORE FRANK IN
5. Social Security Number HOSPILAL enTep KOSEdA H Under 24 Hrs. le 7. Age (In yrs. last birthday) If Under 1 Yea 8. Date of Birth (Month, Day, Birthplaca (State or Foreign Country) **Funeral** Year) Months 1₩ 2□ F Days Hours Director 16,1937 212-34-0591 Usuel Residence of Deced Maryland 62 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f ahon 1 ☐ Yes 2 No Baltimore County Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nd 2 should be filed within 72 hours after deeth with I th and Mental hygiene.
7 Is marked other than "natural", or flama 23a or 2 traumatic event, or Mental Example. USA 21236 7529 Belair Rd. 11 Marital Stalus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Industry Electrician 9th grade N/A Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Pages 1 and 2 should be nant of Heelth and Mental Margaret Hoffman Edward McCarthy 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7529 Belair Rd. Baltimore, Maryland Mrs. Catherine McCarthy mportant: If itam any injury or othe 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremation 3 □ Removel from Stete 2 □ Donation 5 □ Other (Specify) **Department** Baltimore, Md. Parkwood Cemetery 8-7-1999 21. Signature of Funeral Service Licens 22. Nema and Address of Facility Lassahn Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on aach line. Md. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finet Illin Kesislanl STAPHYlococcus Aureus disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) STCOMYELLIS
Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical Renal DISCASE STAGE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certification: 28c. Injury et 28d. Describe how injury occurred After 5 Pending investigation or Attending r deeth. 2 Accident 1 Yes 2 No 24 hours after deet Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
20 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) within 2 \$ 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AASMA 9000 Square DR. BAITIMORE MARYLAND FRANKLIN 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State AUG 10 1999 Registrar DHMH 16 Rev 6/95

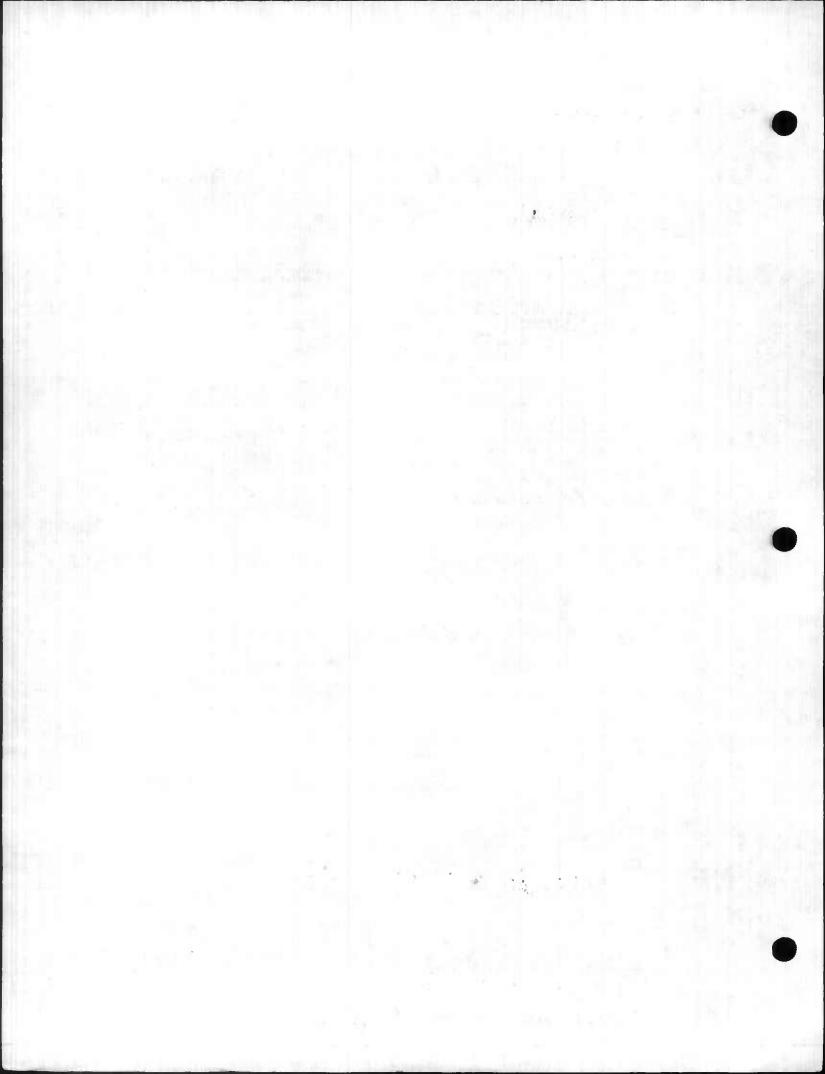
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

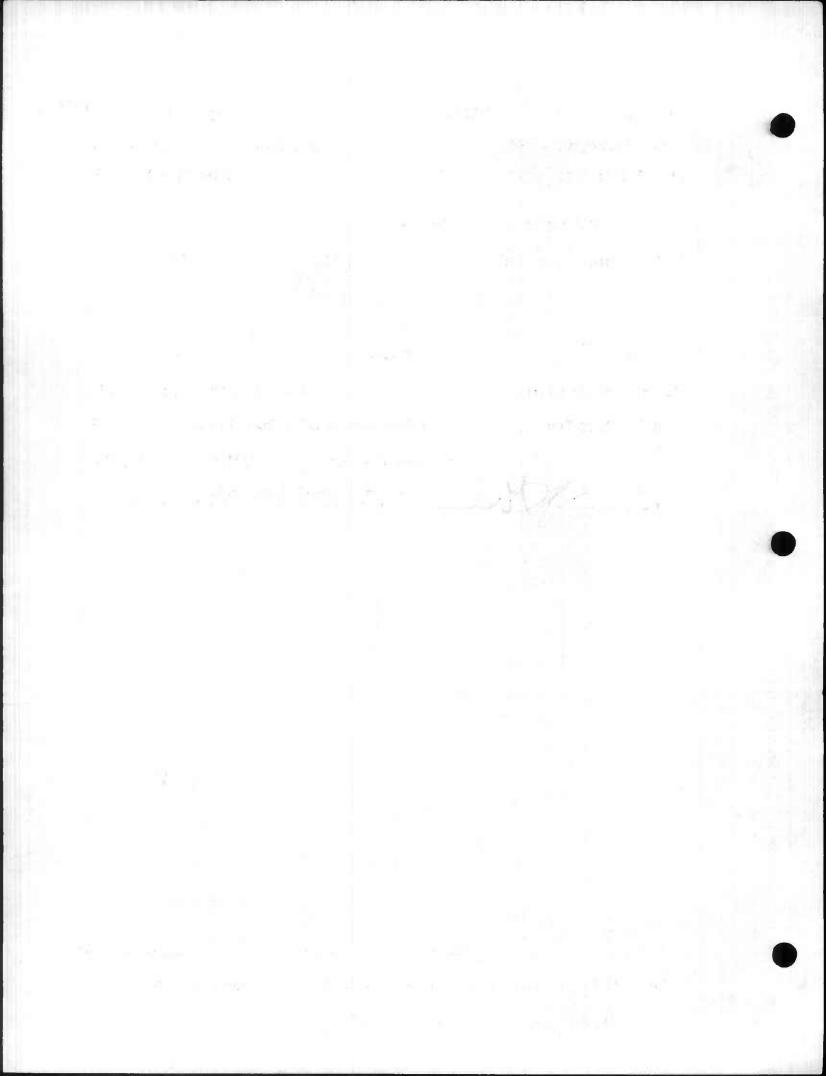
3. Time of Death

2. Date of Death



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					,	Ce	ertificate		Death		Reg. No.	9 4	5032			
Physic	ian	Decedent's Neme (First,	Middle, Last)							2. Dete of D Month	eeth Dey	Year	3. Time of Deeth			
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Exam	iner	4a. Facility Neme (If not ins			nber)				o. City, Town, or			nty of Death				
		13014 Peckto 5. Sociel Security Number	6. Sex		7. Age (In yrs.	last hirthda	/) If Under 1	Yeer	Big Pool	R Date of B	Wash	ningto				
Funera Director		214-48-4161 Usuel Residence of Decede	1□	M 2 X F	8		Months	Deys	Hours Min.	October	irth ley, Year) 14,1911	Cou	ID			
ylend		10a. Stete 10b. C			10c. Cit	y, Town or l	ocation					T	10d. Inside City Limi			
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timent:		4 □ Donation 5 □ Oth	er (Specify)		Par		Cemete			7/31/99	Big Po	ol, MI)			
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/Medical Examiner		fmmedlate Cause (Finel disease or condition Arteriosclerotic Cardio Vascular Disease														
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cord v requir been s should	lete									per	formed?	av	valiable prior to empletion of cause deeth?			
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District of Distri	Certification:	· Carronnolog		Dollon	ig, etc. (Specii)	"				Only or 1.	, ololo,					
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29e. Certifier 1 Certifier (Check only one) 1 Certifier 2 Mer	tifying Phys lical Examin	ician: To the er: On the ba end menn	isis of examine	wledge, dee tion end/or I	th occurred et nvestigetion, is	the tim	e, dete end pleci inion, deeth occi	a, end due to the urred et the time	cause(s) and , dete end plac	mannar as e e, and due t	itated. o the cause(s)			
ro the	Me	29b. Signeture and title of c	ertifier		2		29c.	License	number		29d. Date sig	ned (Month,	Day, Year)			
		- Chir	111	V),	100			DO 1	062		August	3. 1	999			
		30. Name and address of pe	rson who cor	npleted cause	e of deeth (item	23a) (Type						, 1				
		Edward W. Di	tto, 1	III, N	4.D. 2	17 W.	Washin	gto	n St. H	lagersto	wn, MD	217	40			
	ate	31. Dete filed (Month, Dey,	Year)	32. Re	egistrer's Signe	ture										
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year **Physician** Roy Emerson Moon August 07, 1999 5:50 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 918 Ellendale Drive Towson Baltimore Co. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 28, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 11XM 20 F 250-10-2264 Yes 1916 Newark, New Jersey Director Usual Residence of Decedent the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Directo Maryland Baltimore Co. Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò the Medical Examiner must be Items 23a 918 Ellendale Drive 21286-1510 United States of America Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2XMarried "natural", or altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) X-Ray Technologist Radiologist 03 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If New 27 is metriad offine any Injury or other the 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Elizabeth Mathern Frank Judd Moon 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mindelle(nee Seligman)Moon(Wife) 918 Ellendale Drive Towson, Maryland 21286-1510 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corporation 8/10/1999 Towson, Maryland 21. Signature of Funeral Service Licente 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. an 1050 York Rd. Towson, Md. 21204-2515 aux 23a. Part. Eriter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · Coronary Artery disease years Examiner Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequance of) physician as the burial-Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 980 Part fl. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 5 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed D860 has 1 Yes 2 No 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) To. Hospital: Other: 4 Nursing Home 5 E Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 50 Natural 1 | Yes 2 | No 2 Accident 6 Could not be 3 ☐ Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

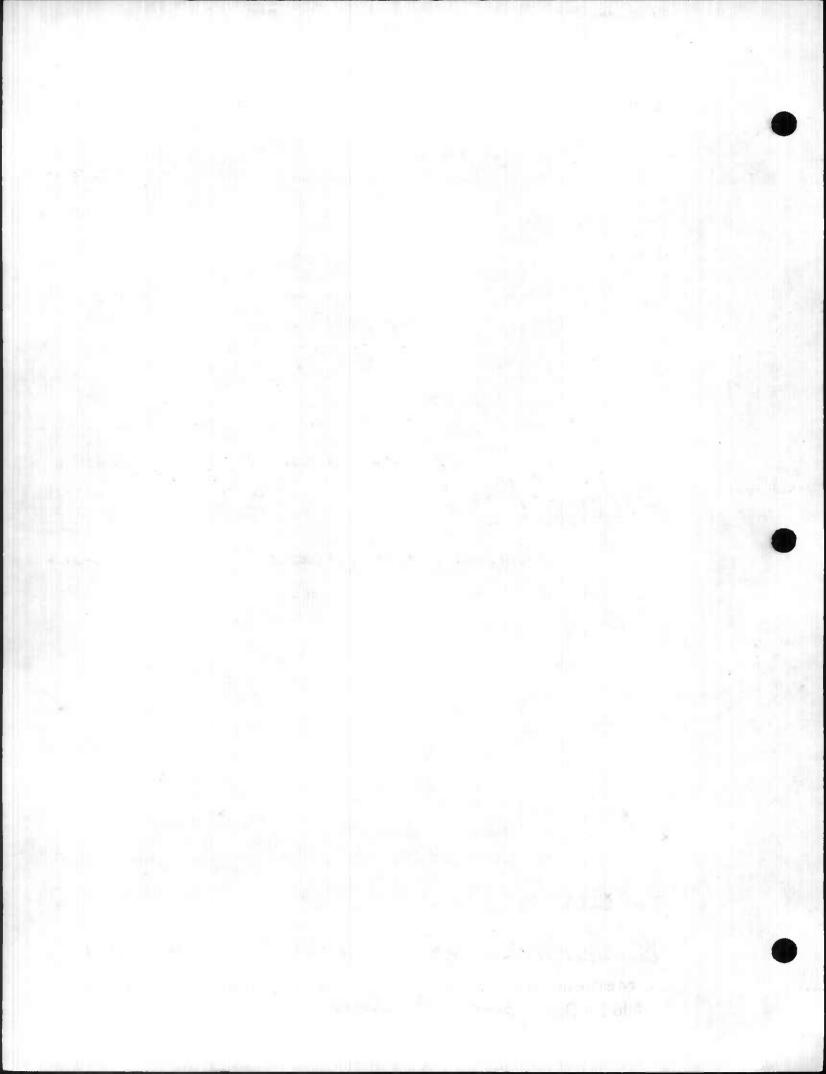
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. edicai 29a. Certifier completely (Check only 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 46168 them, mD Vaniell 30. Name and address of person was completed cause of death (ftem 23a) (Type, Print) Melhem, WD 10755 Falls Rd suite 460 Lutherville, MD 21093

State Registrar 31. Date filed (Month, Day, Year) 999

DHMH 16 Rev 6/95

sporks

3. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 99 25034

	•		C	ertificate o	f Death	R	leg. No.) (.	0034			
Di i	1. Decedant's Name (First, Middla, L	ast)				2. Date of Dea Month	th Day	Yaar	3. Tima of Deeth			
Physician /Medical	Alberta r.	Neun				August	9, 199	9	10:10AN			
Examiner	4a Facility Nama (If not institution, gi				4b. City, Town, o	r Location of Death	4c. County	of Death				
	3900 North Cha				Baltin			/A				
Funeral Director	214-26-7973	Sex 1□M 2M F	(In yrs. last birthda 100 Yrs.	y) If Under 1 Ya Months Day			Year)	9. Birthpla Countr Mary	ca (Stata or Foraign			
pug *	Usual Rasidence of Decedant 10a. Stata 10b. County	1.	10c. City, Town or	Location				100	d. Inside City Limits			
Manyl A	Maryland N/A		Balti						1X Yes 2 No			
28e	10e. Street and Number		Daiti	10f. Zip Code	9	1	l0g. Citizan of	What Countr	y?			
3a o	3900 North Char	les Street	Apt. 802		21218		Unite	d Stat	tes			
offer death with the Ma r thems 23a or 28a-fe ning must be noting	11. Marital Status	12. Was Decedent Ev Armed Forces?			f Hispanic Origin?	(Specify Yes or No- arto Rican, atc.)		ce - Amarica ck, Whita, at				
Urs or Fir.	3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yas, Give Year or Dates:		1 ☐ Yas 2 No Specify: Specify: Whi								
72 hours	15. Decedent's E	Education rade completed)	16a. Dec	edent's Usual Occ	cupation ne during most of w ired)	orking	16b. Kind of B	istry				
and 21215-0 be filed within 72 ho ntal Hygiene. In other than "nature event, the Hindical Be Commisted.	Elementary/Secondary (0-12)	College (1-4or 5+)	life				0					
	11 17. Father's Nama (First, Middla, Las	()		Homema		ama (First, Middle,		n Home	}			
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Larylan 2 should b and Ments and Ments and marked aumatic e	19a. Informant's Name/Ralationship	r, City or Town,	State. Zip C	Code)								
CENL	Richard Kehs / N					tonsville						
D - I 2 2	20a. Method of Disposition	Српси	20b. Place of Dis	position (Nama of rematory or other)			20c. Location					
Pegas nant of mt: If its iry or o	1 🕅 Burlal 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec					v 8/12/99	Balt	imore.	Maryland			
# # # # # # # # # # # # # # # # # # #	4 Donation 5 Dothar (Specify) Immanuel Lutheran Cemetery 8/12/99 Baltimore, Marylan 21. Signature of Funeral Sarvice Licensed Timothy Harman Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, Maryland 21214											
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/Medical	Immediata Causa (Final disease or condition	Musc	list.	In/	- chiam			1	um calite			
Examiner	Immediata Causa (Final disease or condition resulting in death) a. My o Car lind Infraction Dua to (or as a consequence of): b. Coronary Artery Disease											
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68 / 60, tificate be executed gphysician end as the bunal-transit	Sequentially list conditions, if any, leading to immediate											
Dough De S	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initialed events											
ficate be en physician is the buria	rasulting in death) Last	Di	ue to (or as a cons	equence of):								
25 00 00 00												
II RECOIDS, P.O. BOX The law requires that the death cer tate has been signed by the attendir page 2 should be detached for use Completed by PhysicianA	Part II. Other significant conditions	contributing to death but	not reculting in the	undorhina causa	chien in Part I	23h Did t	obacco use co	ntribute to	the cause of death?			
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OT VITA Physicien: rithis cartific inal director,	1 Yes 28 No	Hospital: 1 Inpatient		BILL SEL DON	Othar: 4 Nursing		enca 6 □Otl					
ng P unare unare unare	27. Mannar of Death 1 Shlatural 5 Pending	28a. Dete of Injury (Month, Day)	Year) 28b. Tima Injun	· V		28d. Describe h	ow injury occur	med				
SIO Seath Seath tor: A thaf	2 Accident investigation 3 Sulcide 6 Could not				☐ Yas 2 ☐ No	28f. Location (S	ternada and Alumi	has as Domi	Pouts Number			
UIVISION C below Attending P is after death. of Director: After t led in by the funeral	4 Homicida detarmined		y - At home, tarm, (Specify)	street, tectory, offi	08	City or Tow		ber or Murai	Noble Number,			
UIVISION OF To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To		hysician: To the best of miner: On the basis of e	xamination and/or	ath occurred at the investigation, in m	tima, data and pla y opinion, death oc	ce, and due to tha c curred et the tima, c	eause(s) and m	annar as sta	ited. the cause(s)			
ithin 2 or the omple	one) 29b. Signatura and titla of certifier	and manner stete	u.	29c. Lice	ense number		29d. Data signe	ed (Month, D	Pay, Year)			
ठ में € म	M1111	///	nes	022	342							
	30. Nama and addrass of person who	completed cause of dea			-> 7 /-		August	10, 1	.999			
	Michael N. Rubi				oot Suite	501 Ral	timoro	MD				
State	31. Data filed (Month AUG 1 0	32. Registrar	s Signature	1		. JUL Dal	ormore,	שויו				
Registrar	AUG I U	1999	wa /	J. doo	uls							

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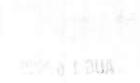
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State of Maryland / Department of Health and Mental Hygiene 9 9 2.5 0 3 5

Certificate of Death

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Physici /Medic		Decedent's Name (First, Middle, L SHAWN C N					2. Date of De Month AUGUS	Dey Year 0345		3. Time of Death 0345 AM					
Examin		4a Facility Name (If not institution, g 2100 BLOCK OF 1			r		4b. City, To-		ocation of Death RE	4c. County					
Funeral Director		074-60-9766	Sex 7 1⊠¥M 2□F		. last birthday) 24 Yrs.	If Under 1 Year Months Dey		24 Hrs. Min.	8. Date of Bin (Month, Da NOV 10	Day, Year)		place (State or Foreign htry) YORK			
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County NEW YORK N/	A		ity, Town or Lo						1	1 ☐ Yes 200000			
4 28 P	ire	10e. Streef and Number				10f. Zip Code				10g. Citizen of V	What Cour	ntry?			
th will	aic	120 CA SALS P	LACE #33	L-J		10	475			U.S.A					
and X1X15-UUZU De filed within 72 hours efter death with the Manyland itel hygiene. Ad other than "natural", or flows 23a or 28e-f ehow event, the Medical Employment and be notified.	by Funeral Director	11. Marital Stetus 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Ves 2 If Yes, Give Year or Det	es?		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🛱 🕅		gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	14. Rac Blac Specify	ck, White,	ACK Industry Tip Coda) 10031 Town, State			
5-0 72 hc	P	15. Decedent's E (Specify only highest g	ducation		16a. Deced	dent's Usuel Occi	upation	of work	ina	16b. Kind of Bu	usiness/In	dustry			
Z1Z15-00Z0 d within 72 hours et giene. r then "naturel", or the man "naturel", or the ma	To Be Completed	Elemantary/Secondary (0-12) 12th grade	College (1-4	4or 5+)	DO NOT use retir	retired)			NONE						
Maryland 212 d 2 should be filed with th end Mentel Hygiene. 7 le marked other that traumatic event, the		17. Father's Neme (First, Middle, Last CRAIG NEWTON	t)						e (First, Middle, CLARK	Maidan Suman	10)				
10		19a. Informant'a Name/Relationship Cynthia Clark/M					Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Onvent Avenue, New York, New York l								
Baltimore, Permit, Pages 1 er Department of Nea mportant: if Nem; my Injury or other				tata	cemetery, crer	ce of Disposition (Name of Date 20c. Location - Ci									
Baltimore, M permit. Pages 1 and 2 Department of Health e important: if Nem 27 is eny injury or other tra		1XXXII 2 Cremetion 3 Ramoval from Stata 4 Donation 5 Other (Specify) Forest Green Cemetery 8-12-99 Morganville, No. 21. Signeture of Funeral Disprey Learners WILLIAM C BROWN COMMUNITY FUNERAL HOME PA. 1206 W NORTH AVENUE													
Physician /Medical Examiner	ner	23a. Part / Enfer the disease, of co- ahock, or heart failure. List only Immediate Causa (Finel disease or condition resulting in death)		'IPLE]	INJURIE or as a consec	S	ring, such es	cerdiac	or respiretory a	rrest,		Approximete Intarval Batween Onset and Deeth			
OX DS/DU, certificate be executed anding physician and use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, teading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):													
			-												
	Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse give							23b. Did tobecco use contributs to the cause 1 Yes 2 200 3 Probably 4						
S s s s	Completed by					performed? available pri			ara autopsy findings allable prior to impletion of ceuse death?						
The law ate has be page 2 s	Sol								XX	Yes 2 No	×	¥Yes 2□ No			
ysicien: The lis certificate ha	Be	25. Was cese referred to medical examiner?					26. Place	of Deat	h (Check only o	one)	1				
VISION OF VITA Attending Physicien: or death. ector: After this certific by the funeral director,	2	1 Netural 5 Pending	28a. Date of (Month,	Injury Dey Year)	28b. Time of Injury	28c. Inj	ury et ork?		28d. Describe I	dence 6 South	red				
LIVISION Hospital or Attending I 24 hours after death. Funeral Director: After	Certification:	Accident investigation 3 Sulcide 6 Could not	28e. Place o		(y)	eet, factory, office	252	20	MOTOR VEHICLE COLLISION 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 2100 FRANKLIN S						
UNISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C														
To the within 2 To the comple	X	29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, D										Dey, Year)			
	O.C.M.E. AUGUST 6, 1999 30. Name and addrass of person who completed ceuse of daeth (Item 23a) (Type, Print)										1999				
1/5		Dennis J (hute	MD 11	11 Penn	Street,		mor	e, Mary	land 212	201				
Stat Registra	te ar	31. Date filed (MAUGa 1 70") 19	99 32.500	istrar's Signi	g.	Spork									

Registrar

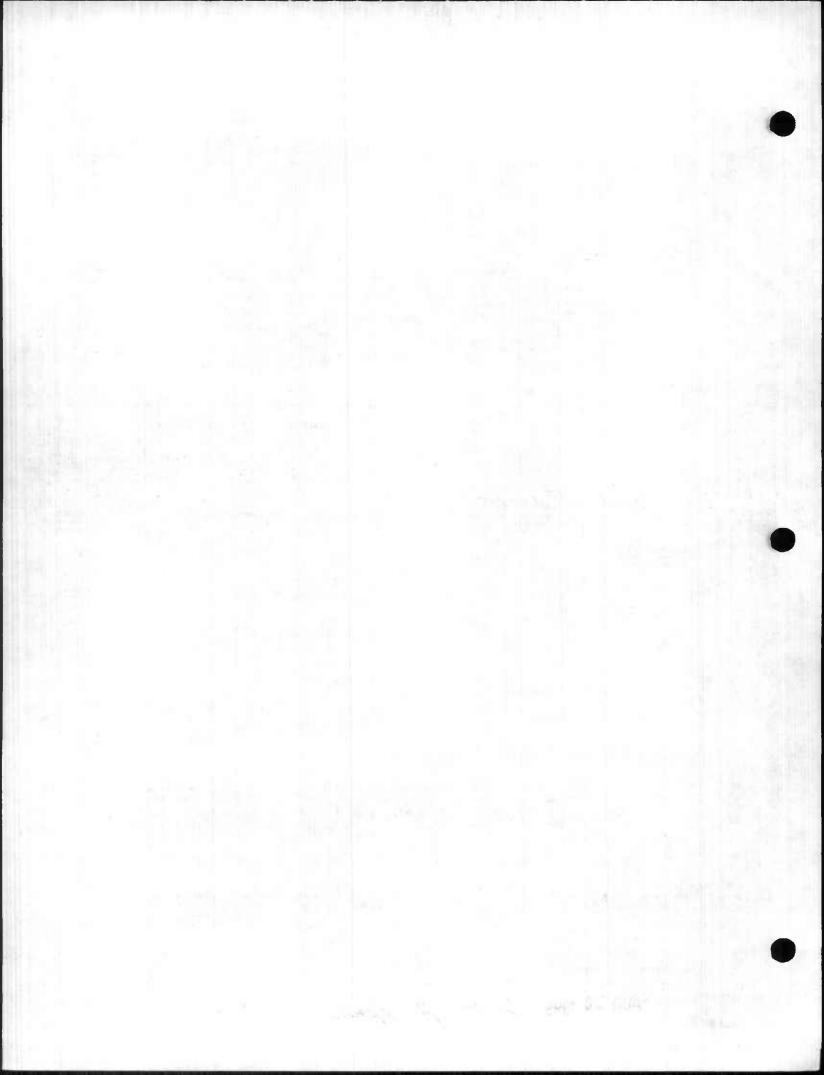


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 922 Month **Physician** Dorothy Nelson 5 1999 August /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayriew Hospital Baltimore Johns Hosplans NA If Under 1 Year Months Deys If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Funeral Months 1 □ M 2 □ F Hours 62 216-34-1446 Director 08-08-36 MD Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD NA Baltimore X Ves 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6 234 5503 Plymouth Road USA 21214 death Funeral Herma 2 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Yeer or Detes: 14. Race - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural". ... in page. Bleck, White, etc. 1 ☐ Never Merried X Merried 1 ☐ Yes 2☐No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th Grade Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) James Η. Williams Lorraine Taylor 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2121419a. Informent's Neme/Reletionship (Type, Print) 5213 Loch Raven Blvd. Baltimore, Maryland Paul Nelson+Ruth E. Brown 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete MD Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest VA Cem. 08-11-99 Owings Mills, 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue mor 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) wks Multi-organ Examine Due to (or es a consequence of) Examiner wks Sepsis physician and s the burial-transit The law requires that the death certificate be asscuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): wks ARUS Box 68760. Physician/Medical Due to (or es e consequence of): 080 P.O. ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Renal failure Division of Vital Records, þ 24b. Were sutopsy findings svailable prior to completion of cause of death? been sig 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) 27, Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Netural 2 Accident 5 Pending n 24 hours efter deeth.

Ne Funerel Director: After pletely filled in by the fun 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled is 29a. Certifie 📆 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MD 98021 August 5 1999 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Ba Humore, MD 21224 1. Browner JHBMC Eastern Are

State Registrar

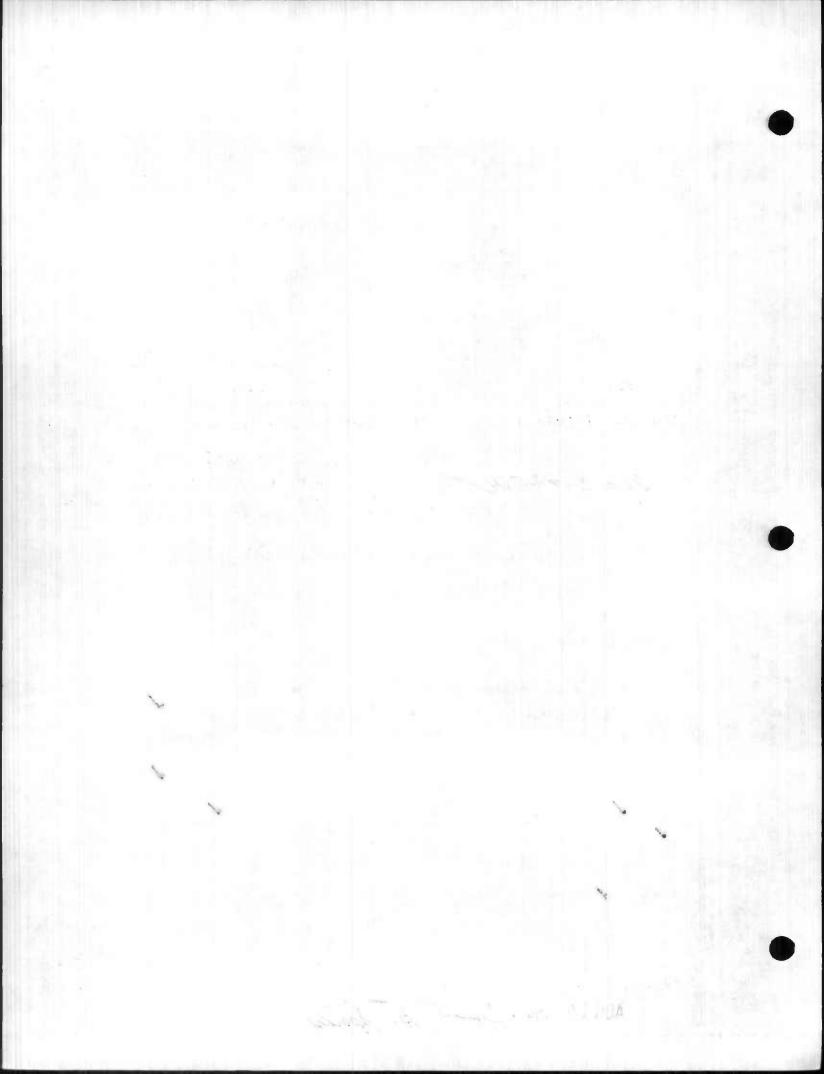
22. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryla		riment of F tificate of			giene 9 9	25037			
	1. Decedent's Name (First, Middle, La	nst)	2. Data of De Month		3. Time of Death						
Physician /Medical		Dieu Thi	Nguye			July	28, 1999	5:00 PM			
Examiner	4a Facility Name (If not institution, gi				4b. City, Town, or I						
92	808 E. Frank		a lant histhdaul	If Under 1 Year	Silver :			gomery			
Funeral Director	619-24-4653 1 M 2XF 73 Yrs. Months Days Houra Min. (Month, Day, Year) SEP 16, 1925 Vie										
land was	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	cation			10d. Inside Cl				
Mary Hely Tor	MD Mont	gomery		S	ilver S	pring		1 ☐ Yes 2 No			
with the Ma or 28a-fe be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of What I	Country?			
23a vi	808 E. Frankli	in Avenue			20901		Vie	tnam			
d 21215-0020 dilide within 72 hours after death with the Maryland Hygiene. thyciene. wither then "natural", or flems 23a or 28a-1 show mit, the Hed call Laminar fruits the morified at a Completed by Funeral Director	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	16	Vas Decedent of Nes, specify Cub ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	No- 14. Rece - American Indian, Black, White, etc. Specify: Asian					
21215-0020 d within 72 hours aft giene. r than "natural", or in Medical Essen completed by F	15. Decedent's E	ducation	Yeer or Detes: 16a. Decedent's Usual Occ			1	16b. Kind of Business/Industry				
Ind 21215-0 be filed within 72 ho tal Hygiene, d other than "natura event, the Hedical Be Completed	(Specify only highest gr Elementery/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give I	kind of work done O NOT use retire	during most of word)	rking					
aryland 212: should be filed within should be filed within marked other than imatic event, the H	5		Ne	ver Wo	rked		N/A	N/A			
E SES M	17. Father's Name (First, Middle, Last)					ne (First, Middle, Maiden Sumeme)				
Marylan d 2 should be th and Mental 7 is marked or treumetic eve	Unk.	Con Dist	400 04-11/-	- Add (Ct)		nk.	Cit T Create	Tio Codel			
May day	19a. Informent's Name/Relationship Son Tran / fri	end		Woodla			er, City or Town, State				
other tr	20a. Method of Disposition		Place of Dispos	sition (Neme of		Date	gfield, V				
0 20 = 3	1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	etro Cr	ematory,	Inc. 08	3/05/99	Baltimo	ore, MD			
Baltim pemit. Pac Department Important: any Injury once.	21. Signature of Funerel Service Lice George E.	MacNabb					D, Inc.	MD 21228			
	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dear						Approximate Interval Between			
Physician	Onset and										
/Medical : Examiner	Immediate Cause (Final disease or condition resulting in death) a. CORONARY ARTERY DISEASE Due to (or es e consequence of):										
secuted and ital-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
O, exec an an risi-tr											
58760, icate be executed physician and s the burial-transit edical Examir											
Box 6 eath certific ettending p for use as		U .									
IS, P.O. BOX res that the death certi igned by the estending be detached for use a by Physician/M	Part II. Other significant conditions	contributing to death but not re		23b. Did tobacco use contribute to the cause of death? 1 Yes 25f No 3 Probably 4 Unknown							
P detay	S/ CEREB	RAL VA-	10								
requir been s should	17	RAL VA:	24a. Was	. Was an autopsy performed? 24b. Were autopsy findin available prior to completion of cause of death?							
2 5 5 5						10	1 Yes 2 No 1 Yes 2 No				
r Vital ysicien: The securiticate director, pag	25. Was case referred to medical exeminer?				26. Place of Dec	eth (Check only	one)				
To To	1 Yes 2 No		☐ ER/Outpatient	3LI DUA		ng Home 5 Residence 8 □Other (Specify)					
Division of Vital tal or Attending Physician: T as after death. al Director: After this certificat led in by the funeral director, po Certification: To Be C.	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 Yes 2 No					28d. Describe how injury occurred			
Division or Attendinate after death. Unrector: A d in by the factor of	3 Suicide 6 Could not be determined	28e. Placa of Injury - At building, etc. (Spec	home, farm, stre	et, factory, offica		28f. Location (City or To	Location (Street and Number or Rurel Route Number, City or Town, Stete)				
Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Competely filled in by the funeral Medical Certification	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example (Check only one)	Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(a)									
To within	29b. Signeture end title of certifier	^		29c. Licens	se number		29d. Dete signed (Mo	onth, Dey, Year)			
· PA	fiste	- no		D29	616	A	lugust 3,	1999			
1)0	30. Name and address of corson who					1					
State	Truong X Hoan 31. Date filed (Month, Dey, Year)	32. Registrar's Sign	nature	nivers:	ity Blvo	a. Silv	er Sptin	ng, MD 20901			
Registrar	AUG 1 0 1	999 Eeneva	Ø.	door	2			12.00			

DHMH 16 Rev 6/95



State Registrar 31. Date filed (Month, Dey, Year) AUG 1 0 1999

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30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print)

32. Registrar's Signature

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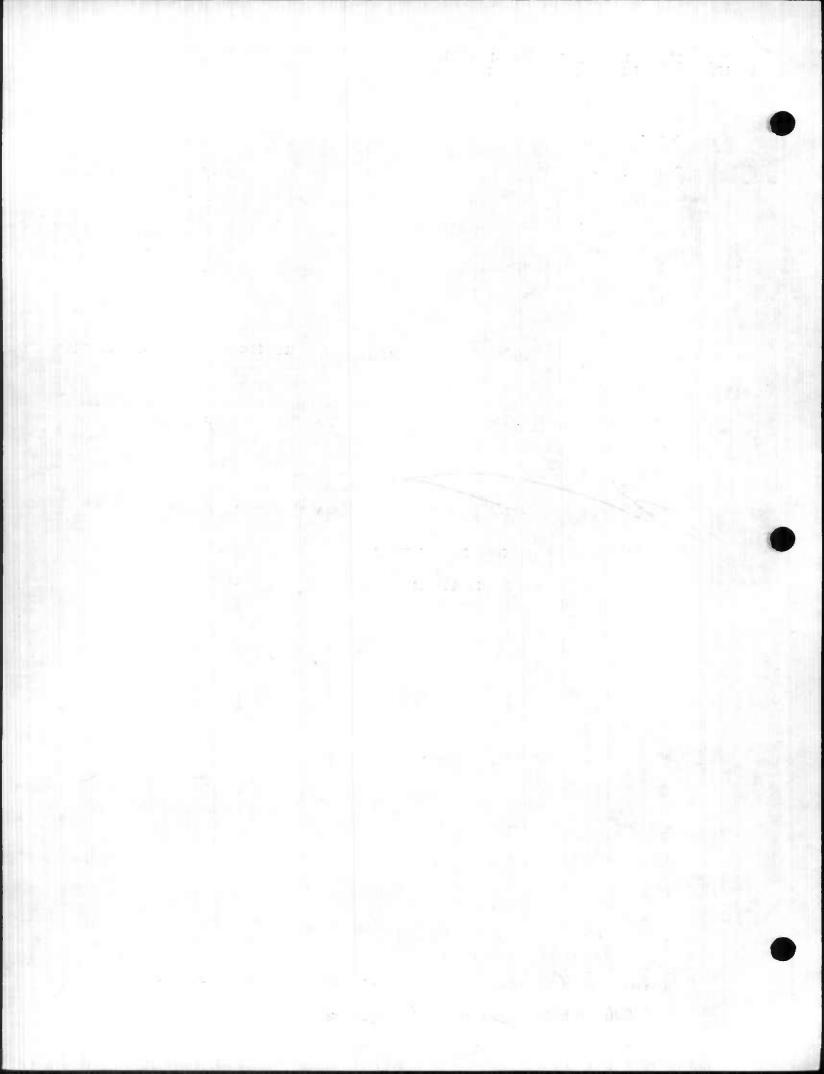
. Sports

OCME

111 Penn Street, Baltimore, Maryland 21201

4, 1999

AUGUST



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Deeth 3. Time of Death Year 2110 PM **Physician** Neville RACEY AUGUST 3, 1999 /Medical 4a Facility Name (If hot institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 506 GLEN ALLEN DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 10 M 20 F 220-86-2 146 Usuat Residence of Decedent Yrs. November 25,1971 Director MARYENd 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahov BAHimore Ves 2□No Director YARyland none 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? r than "natural", or itema 23a or the Medical Examiner must be DRIVE 21229 UCA 206 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 Yas 2 No If Yes, Give 13. Was Decadent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours efter nest of Health and Mentel Hygiene. nts if item 27 is marked other than "natural", or the try or other traumatic event, Tra Marical Examin 1 Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: à ICAN AMERICAN 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use jetired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Stock Clerk Value City Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1a Rence HAZEL Leville 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edmondson Baltimore red 21229 leville Mother Ave 20b. Place of Disposition (Nama of cemetery, crematory or other placa) /Date 20c. Location - City or Town, Stete 20a. Method of Disposition Buriel 2 Cramation 3 Removal from State LANSdowne, HARGLand Department important: If any Injury or Zion 4 Donation 5 Other (Specify) 22. Neme end Address of Facility NANCY M. WALLACE 21. Signature of Funeral Service Licenses FUNERAL SONE 3405 W. FRANKlin Street BALLIMOR, maryland m. Welse 21229 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onset end Deeth Physician /Medical tmmediete Cause (Final disaasa or condition resulting in deeth) Narcotic and Cocaine Intoxication Examiner Due to (or as a consequenca of): Examiner The law requires that the death certificete be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequenca of): Box 68760, Physician/Medical Dua to (or as a consequence of): 8 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p Records, 200 24b. Were autopsy findings avellabla prior to completion of causa of death? 24a. Was an autopsy performed? Completed page 2 2 No 1 PYes 2□ No of Vital or Attending Physicien: Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) TXXYes 2□ No this 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28e. Dete of tnjury (Month, Day Year) 28c. Injury et Work? Aftert 5 Pending investigation Found 8/3/99Found 8:30PM Division 1 Neturet 1 Yes 2 No 24 hours after deeth. Funerei Director: A Unknown 2 Accident the 6 🕅 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide home 506 Glen Allen Dr.Balto.City,MI Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, dete and piece, end due to the ceuse(s) and menner as stated. within 24 hor To the Fune completely fi 2 XModical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifiar 29c. License number O.C.M.E. AUGUST 4, 1999 of person who completed cause of deeth (Item 23a) (Type, Print) estauer 111 Penn Street, Baltimore, Maryland 21201 C 5

Registrar **DHMH 16 Rev 6/95**

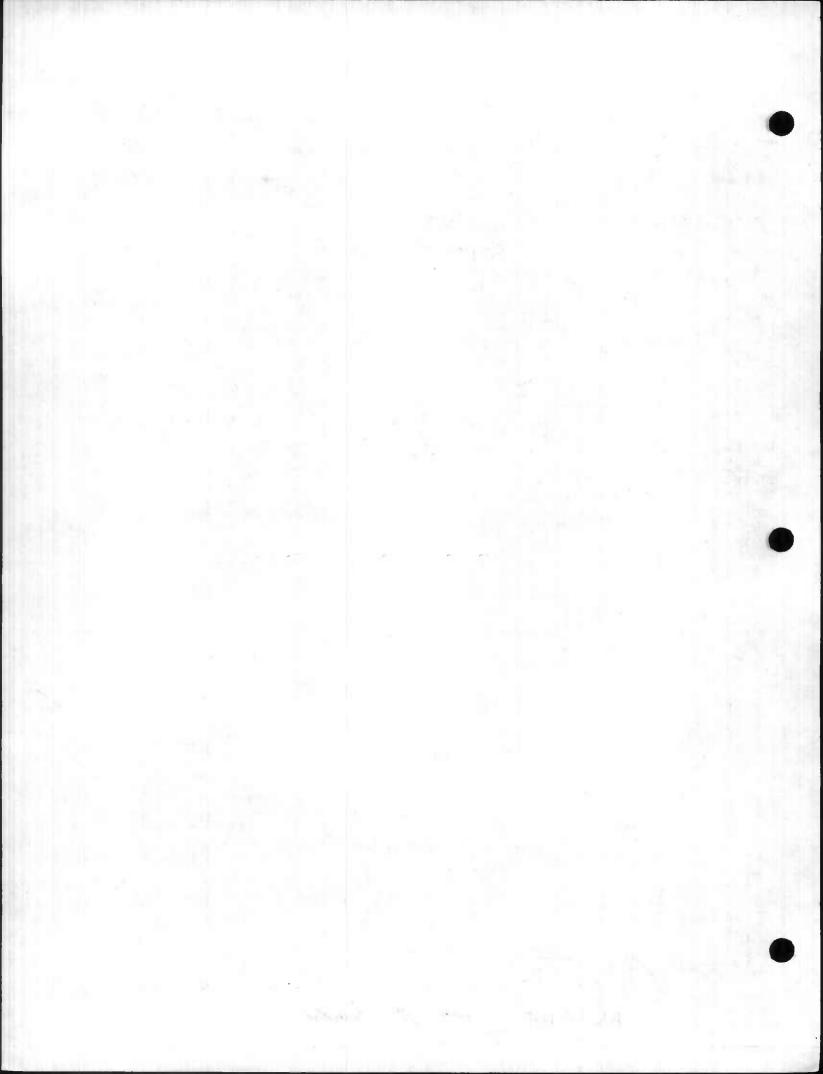
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find (Month, Day, Year)

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1999

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 25040 LORI NOBLE Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Noble JULY 31, 1999 4a Facility Name (If not institution, give street and number) 0825 AM /Medical 4b. City. Town, or Location of Death 4c. County of Deeth Examiner UNIVERSITY HOSPITAL BALTIMORE Baltimore If Under 1 Year | If Under 24 Hrs.] 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 2 F Days Hours Feb. 9, 1968 Handuer, PA 163-54-5962 Usuel Residence of Decedent Yrs. Director with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Bonneauville 1XYes 2□No Directo 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 325 Locust United Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after or and of Healin and Medical Hygiene.
ant: If ham 27 is marked other than "natural", or he ury or other traumatic svant, fire lead of the fire in the lead of 1 Never Married 2 ☐ Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 1001 4 aborer 12 Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Woller Merle 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ittlestown, PA 17340 Raymond E. Woble 132 Street Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State Courty Cremation 8/4/99 Hampstead, MD 4 ☐ Donetion 5 ☐ Other (Specify) Morsoll 549 Carliste St. 21. Signature of Funeral Service Licen Funeral Home, Tre. Hanover, P.A 17331 wetzel 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediete Cause (Finel diseese or condition resulting in death) /Medical tiple injunies Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avaira-Due to (or es a consequence of): thet initieted events resulting in death) Last as the Due to (or as a consequence of): Box (USB P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy tindings svailable prior to completion of cause of death? page 2 should Be Completed 24a. Wes an autopsy performed? 1⊠Yes 2□No 12 Yes 2 No of Vital or Attanding Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To XX Yes 2□ No this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Division 5 Pending investigation 1 Netural 8:25 s after death. 1 Yes 2 No -31-99 2 Accident accident Motor vehicle the 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Route | 16 | Little town Rd 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 I Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in

State Registrar

Stephen S, 31. Dete filed (Month, Day, Year) AUG 10

Mor

29b. Signature and title of certifier

29e. Certifier

Radentz 32. Hagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E

Adams County, Pennsylvania

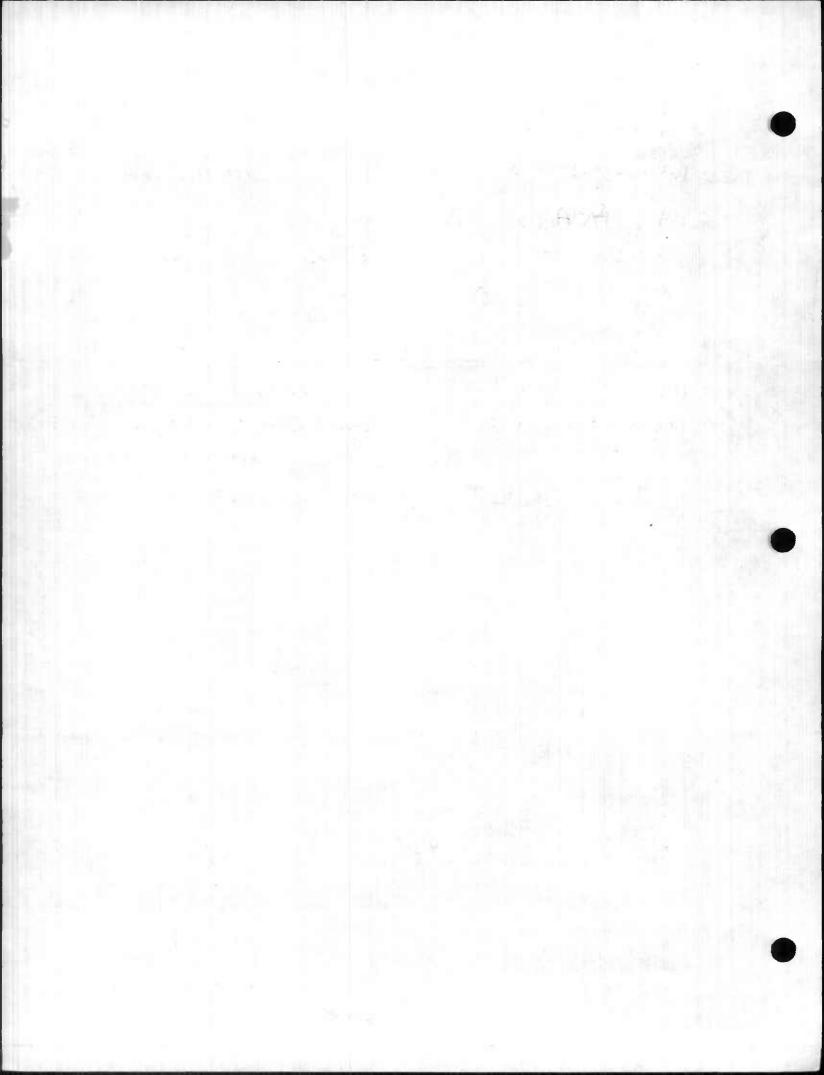
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29d. Date signed (Month, Dey, Year)

1, 1999

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 0035 DWENS 8 CHARLES 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD County General HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Ye 04/11/46 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 15 M 2□ F 216-44-6413 53 Yrs. MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No HOWARD COLUMBIA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9355 RUSTLING LEAF IISA 14. Raca - American Indian, Black, White, etc. 21045 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Specify: BLACK 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Neme (First, Middle, Meiden Sumame) PRINCIPAL 17. Father's Name (First, Middle, Last) JOHN EDWARD OWENS BARBARA ALICE PARKER 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MINNIE S. OWENS, WIFE 9355 RUSTLING LEAF COLUMBIA, MD. 21045 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlai 2 ☐ Cremation 3 ☐ Removal from State MEADOWRIDGE 8/14/99 ELKRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22 Name and Address of Facility JAMES A. MORTON & SONS F. H., INC 1701 LAURENS ST. BALTIMORE, MD. 21217 23a. Pat/f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death tmmedieta Cause (Finel Diabetes disease or condition resulting in death) Due to (or as a consequenca of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Unknown 24a. Was an autopsy performed? 24b. Were autopsy tindings evailable prior to completion of cause of death? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Tnpatient 2ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Box 68760. Physician/Medical Division of Vital Records, P.O. by Completed vin 24 hours after death.

The Funeral Director: After this next leady filled in by the fil Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Completed

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natural, or harns 23a or 25a-f show

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental is marked

Department of Health a Important: If Item 27 is any injury or other tra-once.

Physician /Medical

Examiner

altimore, Maryland 21215-0020

25. Was casa reterred to medical axaminer?

1 Yas 2 No 27. Menner of Death 1 Naturei 2 ☐ Accident 3 ☐ Suicide 4 - Homicide 29a. Certifier

(Check only one)

Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. License number
D 42 465

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

MD. ZKNOII NORTH DV. Columbia.MD, 21045. NILIAM SAWAI

State Registrar

edicai

31. Date filed (Month, Dey, Year) 32. Registrar's Signature AUG 10 1999

DHMH 16 Rev 6/95

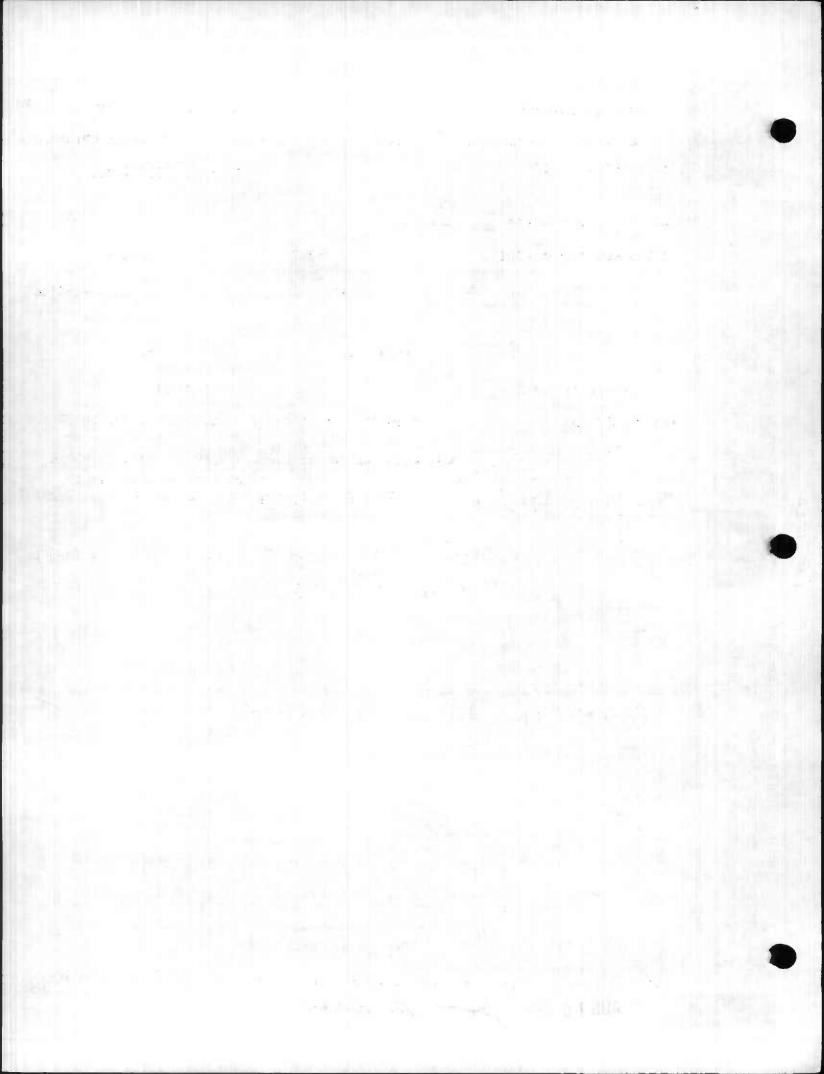
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State of Maryland / Department of Health and Mental Hygiene 2 5 0 1 2

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Funeral Director	5. Social Security Number 6. Sa 215-47-2474	X 7. Aga XM 2□ F	(In yrs. last birthday) 67 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 2	Year) , 1931	9. Birthplace Country) India	e (State or Foreign			
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Hygien Hygien ther the	12	5+							Medical			
S S S E	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)									
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	21 Signature on Funeral Sarvice Liceni	1		. Name and Addr		eck Fune						
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xaminer	Immediate Cause (Final disease or condition rasulting in death) a. CONGESTIVE HEART FALIURE WEEK Due to (or as a consequence of):											
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certificate rector, pag	25. Was case referred to medical				De Dines (D	1 Ve		I Y	'es 2□ No			
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within 2 To the F complete	one) and manner stated. 29b. Signatura and title of cartifiar 29d. Date signed (Month, Day, Year)											
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2	30. Name and address of parson who o	ompleted cause of dea	ath (Item 23a) (Type,	Print) VER	PARKW A	Y GRE	ENRI	ELT	MO			
1	N. 71646H	1.500 14		V - /- 1	17 17	1	- 3		2 7770			
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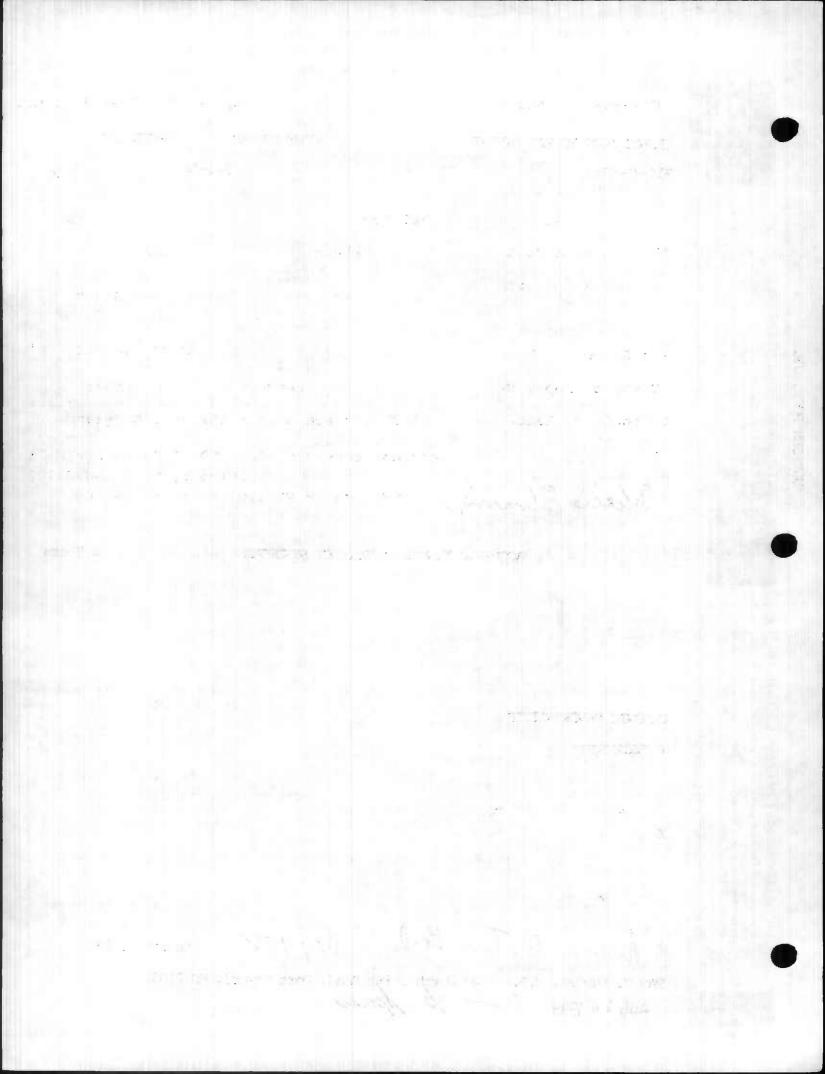
funaral

MINSSES POPE, JR.

within 24 hou To the Fune complately fi Registrar

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death 1999 Ulysses Pope, Jr. 9:35 A.M. August 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) FORT HOWARD BALTIMORE VAMHCS FORT HOWARD DIVISION if Under 1 Yaar | if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) **Funeral** Days Hours 1 NM 2 □ F Yrs. 54 214-40-6164 Director NC Usuel Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Director Baltimore MD NA 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 21239 1927 Swansea Road USA Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 11. Was 2 □ No if Yas, Giva Year or Datas: Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Maritai Status Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yas A No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) Bus Driver Mass Transit Admin 12th Grade 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nema (First, Middla, Last) Be Turner Ulysses Pope, Sr. Reaver 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2123919a. Informant's Name/Raiationship (Type, Print) 1927 Swansea Road Baltimore, Maryland Gertrude P. Henderson 20c. Location - City or Town, Stata MD 20b. Piaca of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 1 Buriai 2 Cramation 3 Ramoval from Stata VA Cem. 08-13-99 Owings Mills, Garrison Forest 4 Donation 5 Othar (Specify) 22. Nama and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onsat and Death death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Immediata Causa (Final disaasa or condition rasulting in daath) a ACQUIRED IMMUNE DEFICIENCY SYNDROME 3 Years Dua to (or as a consaquance of): Examiner Sequentielly list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that Initiatad evants Dua to (or as a consequence of): Physician/Medical Due to (or es e consequenca of): rasulting In daath) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown CHRONIC PANCREATITIS þ 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? HYPERTENSION 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) 1 Yes 2 No Hospitai: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 10 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Pending 1 ☐ Yas 2 ☐ No Investigation 2 Accident 6 Could not be datarminad 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 T Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and titla of cartifian 29c. Licansa number an August 9, 1999 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 9600 North Point Road, Fort Howard, MD 21052 AURORA, M.D. TAN C. 32. Registrar's Signatura State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Aug. 6, 1999

4b. City, Town, or Location of Deeth 4c. Coun Loretta Pritchett 1:30 am 4e. Fecility Neme (If not institution, give street end number)
Manor Care Nursing Home 4c. County of Deeth
Baltimore Rosedale If Under 1 Year if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) Deys 1□ M 2□XF Months Hours 77 214-20-1382 MĎ Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Rosedale 1 Yes 2 No 10e. Street and Number 8115 Woodhaven Rd. 10f. Zip Code 10g. Citizen of Whet Country? 21237 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Detes: 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 0 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme)
Loretta Bright Herbert Deacon 19a. Intorment's Neme/Relationship (Type, Print)
Havlin Pritchett/husband 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8115 Woodhaven Rd. Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, cremetory or other piece)
Gardens of Faith 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 M Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 8-9-99 Baltimore, MD 21. Signeture of Funerei Service Lig 22. Name end Address of Fecility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Final Mar. disease or condition resulting in deeth) Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of) Due to (or as e consequence ot) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes cese reterred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28b. Time ot 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 Accident

Examiner or Attending Physician: The law requires that the death certificeta be assecuted P.O. Box 68760, of Vital Records, Division

Physician/Medical Examiner use as the burial-trensit signed by the signed to detached þ paga 2 should Completed cartificate director. Be Certification: To this the funaral After t

Physician

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Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental hygiene.
ant: if Itam 27 is marked other than "natural", or items 23e or 28e-f show unt; or forther than matural or other than unit or other than the matural or other than the

permit. Page Department of Important: If any injury or

Physician /Medicai

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i Hygiene. other than "natural", or items 23e or 28a-f show rent, the Medical Examiner must be notified at

Funeral Director

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To the Hospital or Attending within 24 hours eftar death.

To the Funeral Director: Afte completally filled in by the fun

State

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. KAHNAMA, 1.7. FONTANA LA. # 105, BALTIMORE, MD 31. Dete tiled (Month, Day, Year) 1 0

1999 ▶

6 Could not be determined

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only onel

29b. Signature and the bertifie

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

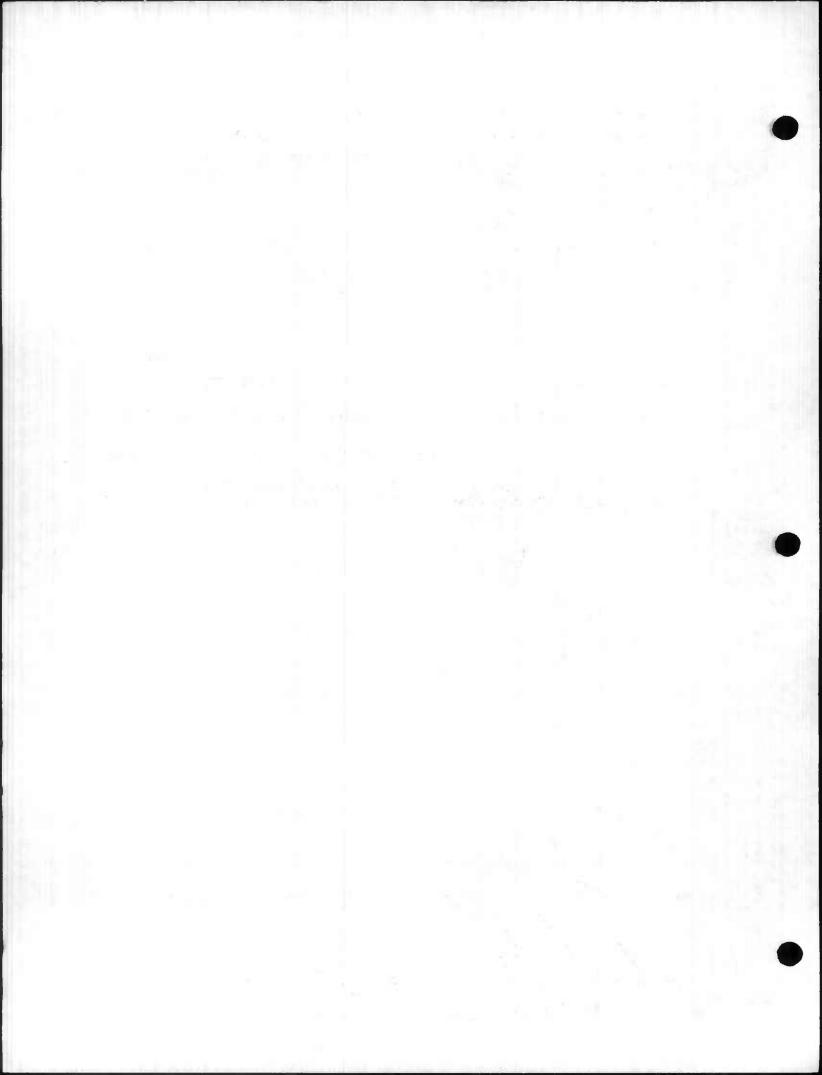
32. Registra s Signeture

1 Certifying Physician: To the best of my included, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated.

29c. License number

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Hedwig Poniatowski A. 7:03 AM August /Medical 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Gilchrist Center - Hospice Towson Baltimore If Undar 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 20, 1915 If Undar 1 Year 5. Sociel Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foraign **Funerai** 1□M 2XF Months Days 83 Yrs. Maryland 214-26-8109 Director Usual Rasidanca of Dacadant 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 4326 Parkside Drive 21206 U. S. A. 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 🌂 No If Yas, Giva 11 Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien. Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yas 2 No Specify: p 3 X Widowad 4 ☐ Divorced White Yaar or Datas: Completed 15. Decedant's Education (Spacify only highast greda complated) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working lifa. DO NOT usa retired) Elamantary/Sacondary (0-12) Collaga (1-4or 5+) 8th Grade Sales Person Restaurant 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Steven Potyraj Nora Unknown 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 26 Greenridge Road, Lutherville, Maryland 21093 Conrad Poniatowski (Son) 20a. Mathod of Disposition 20b. Placa of Disposition (Nema of cematary, crematory or other place) 20c. Location - City or Town, State Date 1 X Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) St. Stanislaus Cemetery 8/12/99 Baltimore, Maryland 21. Signatura of Funaral Sagvice Licanse 22. Nama and Addrass of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213
23a. Part1. Enter tha disease, or complications that canded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximata Intervel Batwean Onsat and Death Physician /Medical Immediata Causa (Final 5 months Ung CANCER disaase or condition rasulting in death) **Examiner** Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated avants Due to (or es a consequence of) Physician/Medical thet initieted avants rasulting in death) Last Dua to (or as a consaguanca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown by 24b. Wara autopsy findings aveilable prior to complation of cause of death? Completed 24e. Wes en autopsy parformed? 1 Yas 2 No 1 □ Yes 2 □ No 25. Was casa referred to medical axaminar? Be 26. Place of Deeth (Chack only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) to Spice Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 2 1 Yes 2X No 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Panding invastigation 1 Natural Injury To the Hosping. ... within 24 hours after death.
To the Funeral Director: A 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 ☐ Suicida 28e. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner stated. edical 29a. Certifier (Check only one) 29b. Signature ond title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 025205 Lus 30. Nama and address of person who completed cause of deeth (from 23e) (Type, Print) Charles St. Bolts. md 21204 Bm (6701 32. Registrár's Signatura

Registrar

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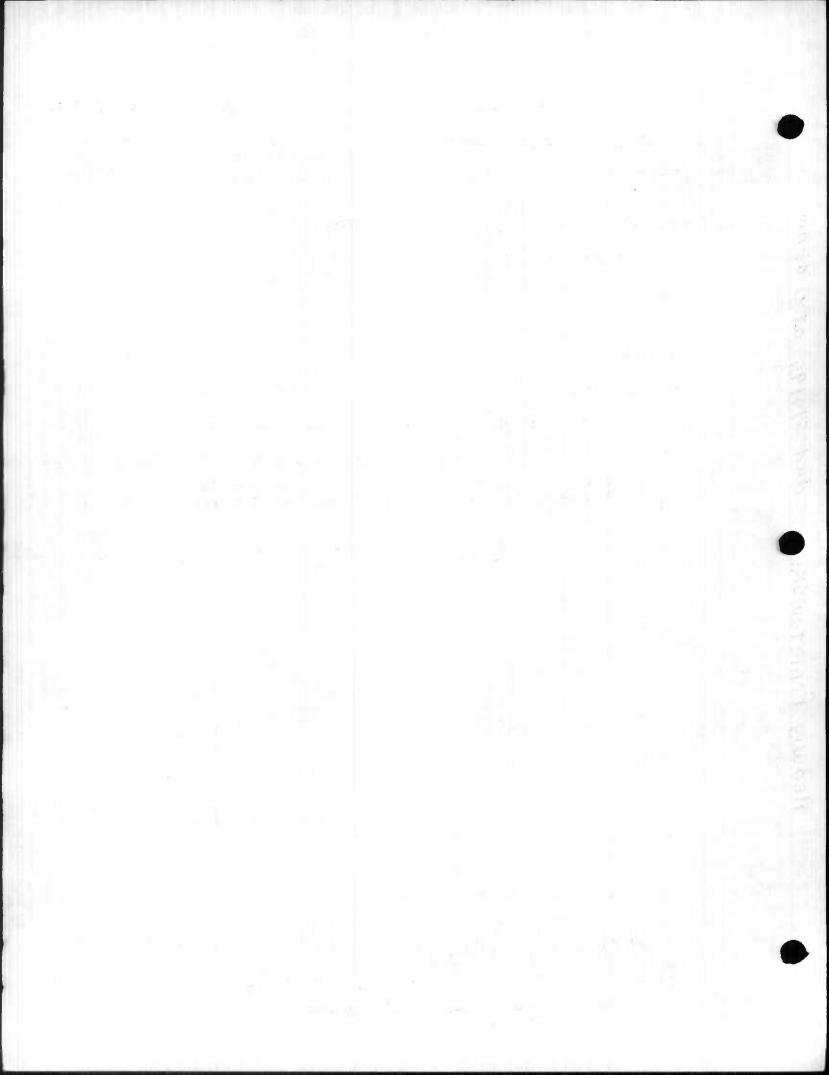
Hedwig Poniatowski

Vital

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death.



State Registrar

29b. Signature and title of certified

30. Name and eddress of person who com

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31. Dale filed Many

STREE

cause of death (Item 23a) (Type, Print)

PENN

2. Registrar's Signature

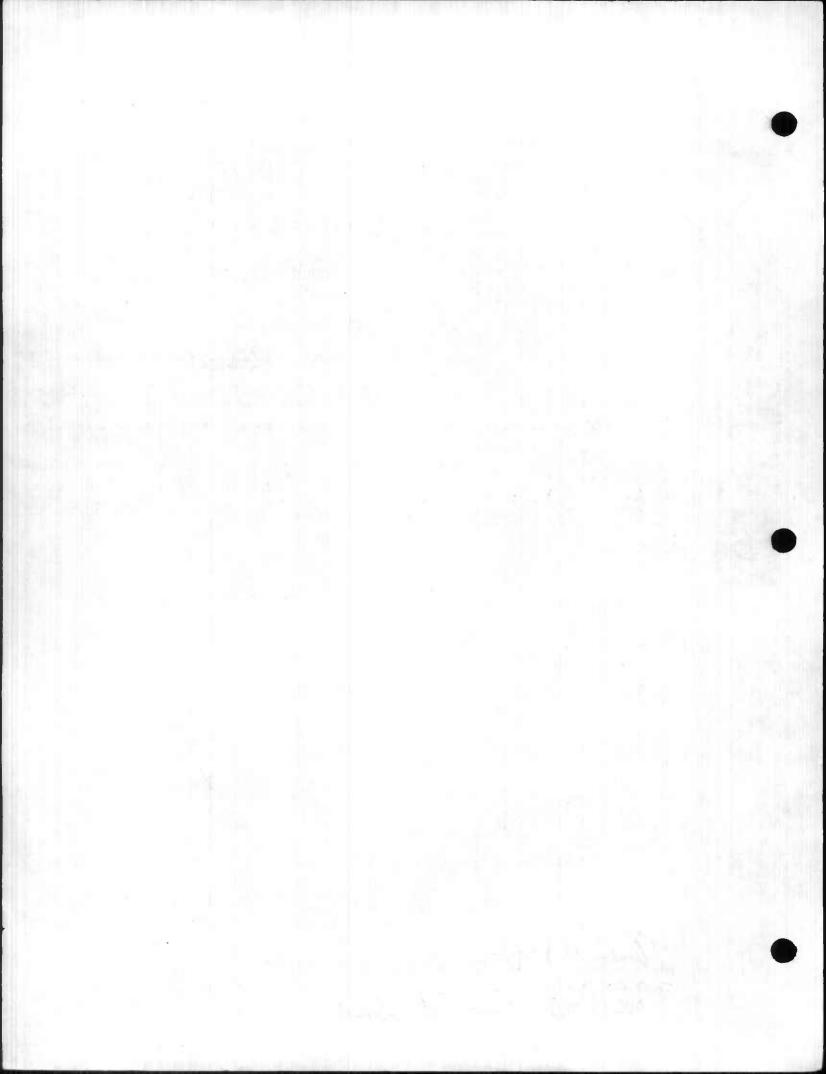
29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August6, 1999

BALTIMORE, MD. 21201



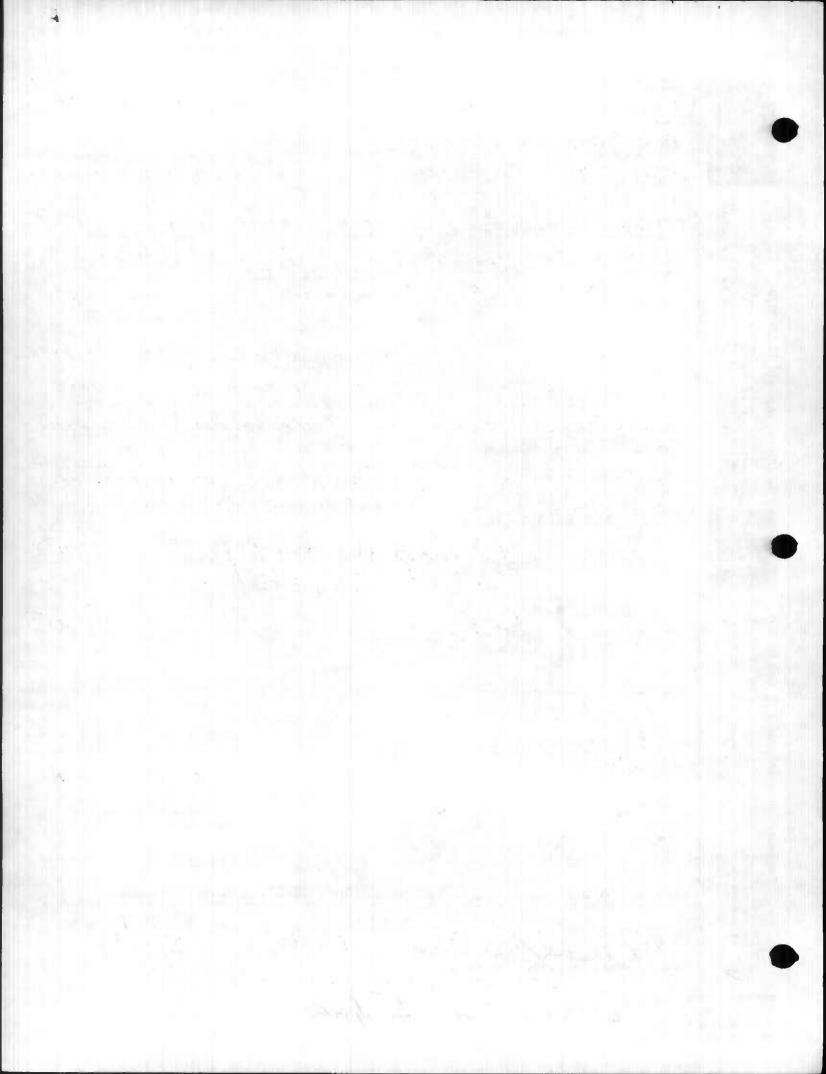
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 248 Month Day **Physician** Spr 1995 Geraldine AUG /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner BALTO tOSPITAL 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 6 Sex **Funeral** 216-36-3844 Min. 1□M 2X F Months Deys Hours 9 Yrs MARY Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manyland Department of Health and Mentel hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other tranmatic event, it a Medical Examines must be notified at 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARYLAND 10g/Citizen of What Country? 10e. Street and Number 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) FAIR MOUNT Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Detes: 14. Raca - American Indian, 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Specify BLACK Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GRADE WORKER BALTO, SUN PAPER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOHN LEGRAND MU SSETHEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2115W. OLIVER SPRIGGS HUSBAND. FAIRMOUNT AVE. BALTO. MD. 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Important: If it any injury or o 12 Suriel 2 Cremetion 3 Removel from Stete 08-12-99 OWINGS MILLS, MD 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST 21. Signature of Funerei Service Licensee 22. Name end Address of Facility
JOSEPHH. BROWN
2140 N. FULTON A JR. FUNERAL HOME AVE. BALTO, MD. 21211 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Physician/Medical Examiner physicien and the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last certificate be exec Division of Vital Records, P.O. Box 68760 Tue to (or es a consequence of) **USB 85** t attending p for use es The law requires that the death ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 10 100 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed peen has page 2 No 2 No 1 Yes After this certificate To the Hospital or Attending Physician: Be director, 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? 1 ☐ Yes 2x No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ■ Natural 2 □ Accident 5 Pending investigation within 24 hours after use.....
To the Funeral Director: Aft 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and placa, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date/signed (Month, Day, Year) 29b. Signatupe and title of Sertifier 29c. License numbe 30. Name and address of person.

32. Registrer's Signeture

State Registrar 31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death Month 08 **Physician** William 8:57 Am /Medical 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner aldercare Home word Baltu bonem If Undar 1 Year 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) If Under 24 Hrs. Birthplaca (State or Foreign Country) **Funeral** 2663 1 M 2□ F 03 Director Usual Rasidanca of Dacedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic avent, the Medical Examiner must be notified at Balto N, A Md Director 1 Yas 2 □ No 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? W1/56Y 4019 4.5.A 21218 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Haelth and Mental Hygiena.
Important: If item 27 is marked other than "natural", or harmony injury or other traumatic ayant. 12. Wes Decedent Evar in U,S.
Armed Forces?
1 ☑ Yas 2 ☐ No / 1 € 2 7/7 2
1 Yas, Giva
Yaar or Dates: J 🏽 7 1 5 / 4/6 Race - American Indien, Bleck, White, etc. 11. Maritel Status Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) W Naver Merried 2 ☐ Married 1 ☐ Yas 2 Ø No Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant'a Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) Sealtest DAIRY Return Depht 12 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Surname) Redding SARAL CHARLES DOFMAN 19a. Informant'a Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARAL W. IS BY AVE Balto, ma 2/2/8 CULLISON 20b. Piace of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition Data 1 Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata Garrison Forest Cem OWINGS Mills, MG 8/12/99 4 Donation 5 Other (Specify) 21. Signeture of Funerel Sarvica Licenses 22. Nama and Addrass of Facility Locks. 23a. Part. Enter the disaasa, or complications that caused tha death. Do not antar the mode of dying, such as cardiec or respiratory arrest shock, or heart failure. List only one cause on each line. Physician Accident Vascular /Medical day Immediata Causa (Final diseesa or condition rasulting in death) Examiner Physician/Medical Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be assecuted Sequantially list conditions, if eny, leading to immadiate cause. Entar Undarlying Cause (Diseese or injury that initiated events rasulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. Dua to (or es e consequance of): cata has been signed by the a page 2 should be dateched to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? tension 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara autopsy findings aveilabla prior to completion of causa of daath? Be Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No certificata director. 25. Was casa raferred to medical 26. Placa of Death (Check only one) 1 Yas 2 No Othar: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar 1 Natural 5 Panding To the Hospital or Attendir within 24 hours eftar death. To the Funeral Director: Af 1 ☐ Yas 2 ☐ No 2 Accidant invastigation 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homicida Medical 29e. Cartifiar 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) end mennar stated. 29b. Signeture end Affile of cartifiar 29c. License number 29d. Data signed (Month, Day, Year) My Sician 30. Nama and address of person who complated ca

3007

-E Northern Park way

DHMH 16 Rev 6/95

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Larry Randolph 5.45 AM August 05 999 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Harbor If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) Days Hours Months 1₩ 2□ F 45 5-26-1954 MD 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2602 ROUND ROAD APT. B2 U.S.A. 14. Race - American Indian, 21225

13. Was Decedent of Hispenic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced AFR. AMERICAN 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) THOMAS RANDOLPH LOUISE RANDOLPH 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) BALTO. MD 21225 DELORES RANDOLPH (SISTER) 2818 DENHAM CIRCLE 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Warial 2 Cremation 3 R moval from State MT. ZION CEMETERY 4 Donation 5 Other (Specify) 8/11/1999 BALTO. CO. 21. Signature of Füneral Service Lio EUSENE N WALKER ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 Approximate interval Between Onset and Death or complications that of used the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, ardiomyopathy Immediate Ceuse (Final disease or condition resulting in deeth) 9 years Advounced intection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequenca of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? infections including 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? peripheral Neuvapathy 24a. Was an autopsy performed? 2100 1 Yes 2010 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

The law requires that the death cartificate be asscuted physician and s the burial-transit Division of Vital Records, P.O. Box 68760, this Affar

Examiner Physician/Medical signed by the a ò Completed cartificata has b lirector, paga 2 s Attending Physician: director, Be P funaral Certification: ne Hospital or Attendit n 24 hours aftar death. ne Funerel Director: A plately filled in by tha fu

Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, in Medical Eventine must be notified at

Physician /Medical

Examiner

Medical To the Hosp within 24 ho To the Fune complately f Registrar

25. Was case referred to medical examiner? 1 ☐ Yes 2 DNo 27. Menner of Death 1 DNetural 2 Accident 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Menou

29c. License number 29d. Date signed (Month, Day, Year)

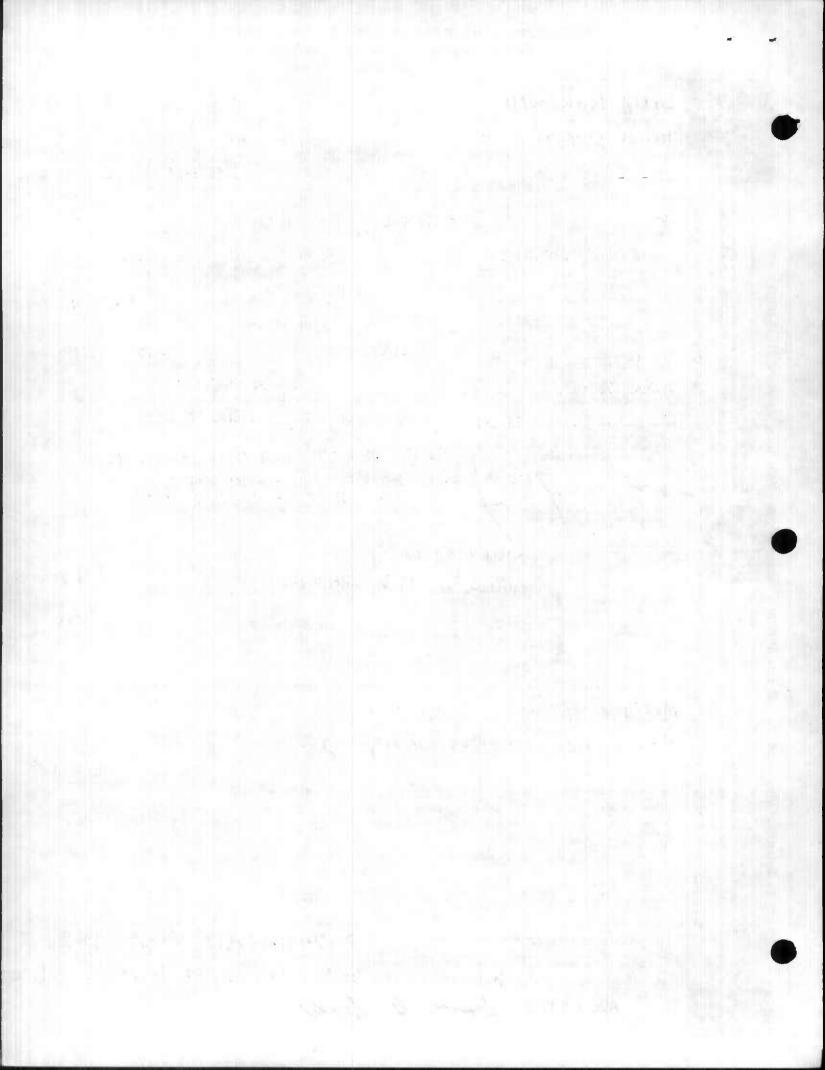
AS 2441614 A33

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Bakleh, Harbar Hospital 3001 South Hanover St, Baltimore, MD2003 Dr. Mohanad

31. Date filed (Month, Pay, Year) AUG 1 0 1999 32. Registrar's Signature

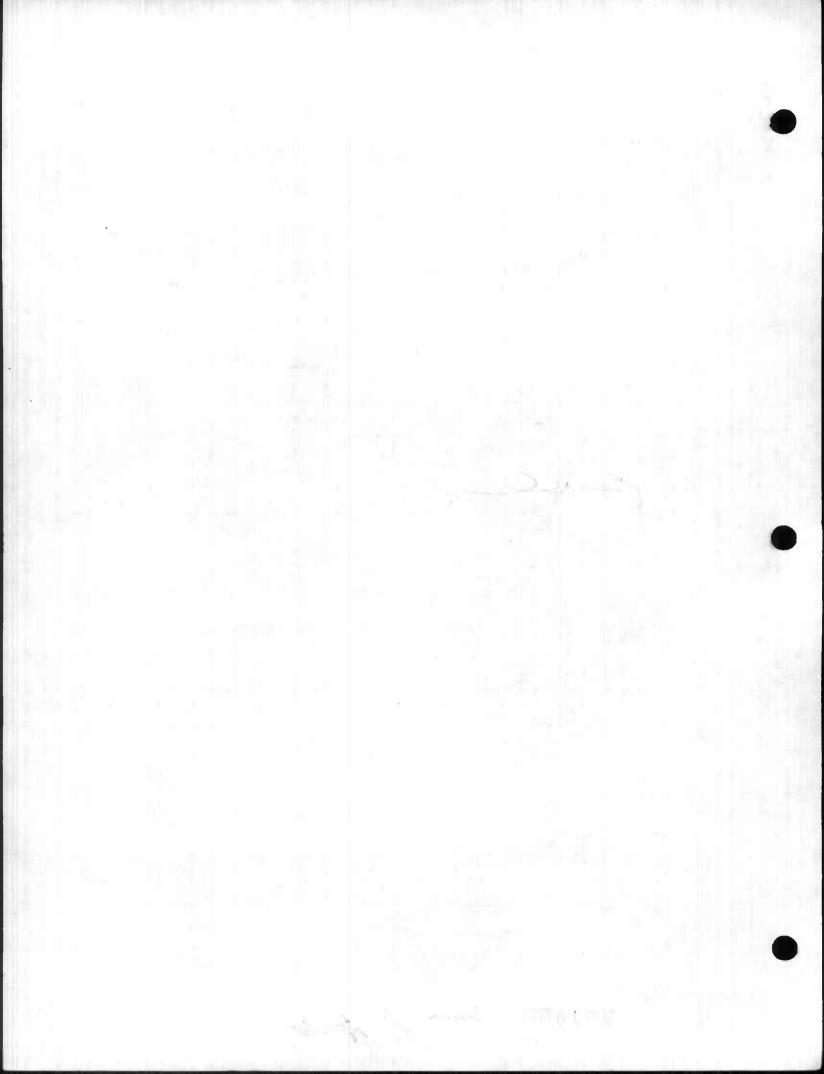
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) Examine	Stella Maris Timoniu	ım	1	Baltimore								
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B and a man	22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093											
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Physician: This certific and director,		ome 5 Reside	ence 6 Other	(Specify)								
ding Ph th. After th funeral		28d. Describe h	ow injury occurred									
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To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated.											
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A11	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	HILLRY	1 212	10								
State			X //									
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ORIGINAL



Baltimore, Maryland 21215-0020

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August 4

ALLEN REED

Physician

/Medical

Division of Vital Records, P.O. Box 68760,

Examin	er	4a. Facility Name (If not institution, give	street and num	iber)				4b. City, Town, or	Location of Dee	th 4c. Count	y of Death		
		STELLA	A MARIS	HOSPIC	E - T	OWSO	N		TOWSO	N		Baltimore		
Funeral		5. Social Security N			7. Age (In yrs	. last birthd	(ay) If Under		If Under 24 Hrs	8. Dete of B	irth	9. Birthplace (State or Foreign		
Director	lly d	219–16–4168 XXM 2□F			73	Yrs	Months .	Days	Hours Min	Sept 2	irth 23,1925	Maryland		
ъ		Usual Residence o	f Decedent					-						
ylan		10a. State	10b. County		10c. C	ity, Town o	r Location					10d. Inside City Limits		
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Instructions: I file marked other than "natural" or items 23a or 28a-f show any injury or other traumatic avent, the Medical Evantiner mant to notified at once.	Funeral Director	Md.	Balt	imore				E	ssex			1 ☐ Yes 為☐ No		
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of He		20a. Method of Dis				cemetery, o	isposition (Nancrematory or o	her plac	ce)	Date		- City or Town, State		
Pag net: H			☐ Cremation 3 ☐ I 5 ☐ Other (Specify)		tate	arder	ns of F	aitl	n Cemete	ry 8/6/9	9 Ross	ville Md.		
mit.		21. Signeture of Fu	uneral Service Licans	ee (1)		4	22. Name en	Addre	dress of Fecility Y Funeral Home of Essex					
Depariment in popular		▶ R	T. 111	160	1	1.						21		
		300 MAce AVe. Baltimore Md. 21221 23a. Part1. Entar tha disease, or completitions that caused the doubt no not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List oply one cause on each lina. Approximation of the mode of dying, such as cardiac or respiratory arrest, interval B												
Physician /Medical Examiner		Immediate Causa disease or condition resulting in death)	(Final		CANCE	R	_	# - No.				Interval Between Onset and Death		
	<u>a</u>				Due to (or as a con	saquence of):							
pe n	Examiner			b. ————————————————————————————————————										
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eath certificete be executed attending physician and for use as the bunal-transit	Ca	cause, Enter Under Cause (Disease or that initiated events	Injury											
ficet phy as th	8	resulting In death) Last Due to (or as a consequence of):												
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hes been signed to 2 should be d	y Physician/Medical	Part II. Other eignificant conditions contributing to death but not rasulting in the underly						iuse giv	en in Part I.		23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
	Completed b										s an autopsy ormed?	24b. Ware autopsy tindings evailable prior to completion of cause of daath?		
	Eo									10	Yes 2 No	1 ☐ Yes 2 ☐ No		
	6)	25. Was case refer	red to medical						26 Place of De					
Physician: r this certific ral director,	OB	examiner? 1 ☐ Yes 2 🔀		lospital:	patient 2] ER/Outpa	tiont 3 DO	26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE						
Phy r this	=	27. Manner of Deat		28a. Date of	Injury	28b. Time		Bc. Injur Wor			how injury occu			
tending I leath. lor: After the funer	atlor	1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation					M M		k? Yes 2 □ No					
after Att	Certification:	3 ☐ Suicide 6 ☐ Could not be detarmIned 28e. Place of Injury - At home building, etc. (Specify)				ome, farm, fy)	, street, factory, office 28f. Location (Street, City or Town, S			(Street and Num own, State)	eet and Number or Rural Route Number, State)			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one)	1⊠ Certifying Phys 2 Medical Exami	nar: On the bas	is of examina	owledga, de ation and/or	eath occurred a r invastigation,	t the tir	ne, data and place pinion, death occ	e, and dua to the urred at the time	causa(s) and m	anner as stated. , and dua to tha causa(s)		
Vithin To the	Me	29b. Signature and	tive of certifier	and mannar stated.				Licans	e number		29d. Date signi	ed (Month, Day, Year)		
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2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

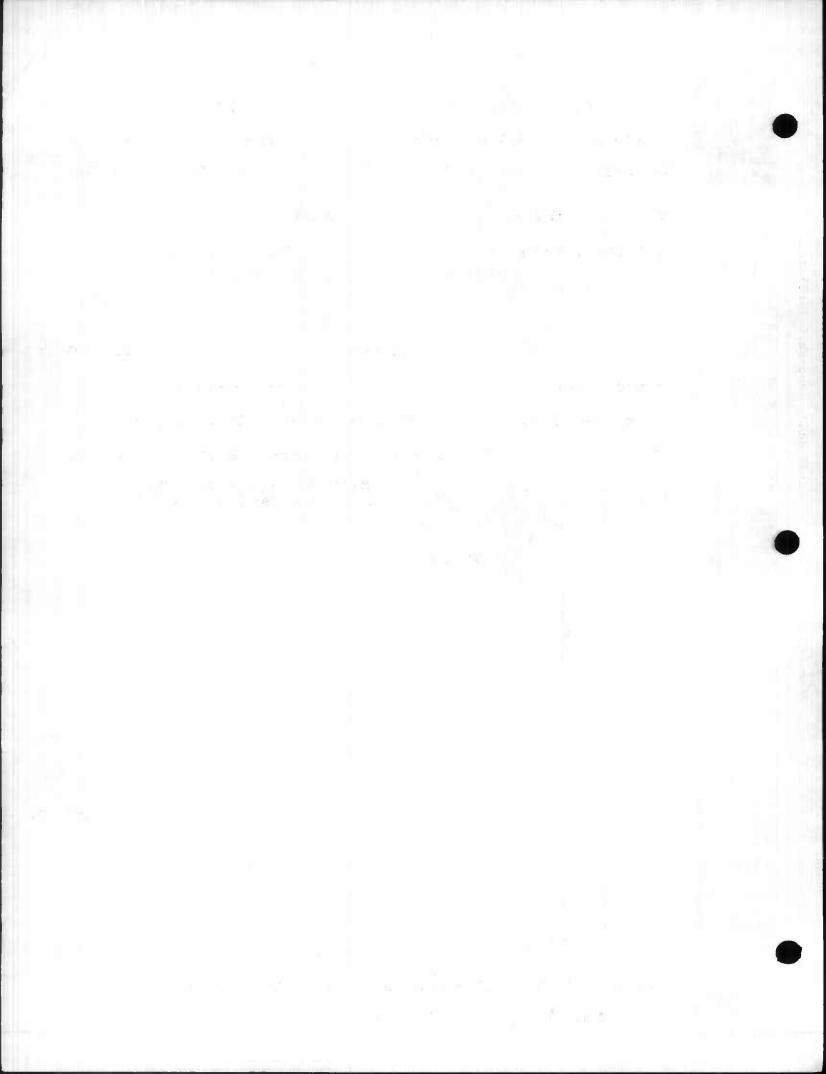
30. Name and addrass of parson who complated cause of death (Itam 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

State Registrar

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death PORINSON 19492:23 **Physician** VELYN TUGUST /Medical 4c. County of Death 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location by Death Examiner more If Under 1 Year 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, 5. Social Security Number 9. Birthplace (Stata or Foreign **Funeral** Days 244-30-864. Usual Residence of Decedent 1 M 2 KF North Carolina Director 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show na 23a or 28a-f ahor Maryland 1 Nas 2 No Funeral Director more 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? d Herma 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11 Marital Status Black, Whita, atc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 21215-0020 1 Yes 2 No Specify: Be Completed by **Hmerican** 3 ☐ Widowed 4 ☐ Divorced AFFICAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 d Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 Is marked other any Injury or other treumatic event para 19a. Informant's Name/Relationship (Type, Print) State, Zip Coda) (Husband) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 10 oodlawr 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License unera 23a. Parti/finiter the diduse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Daath **Physician** Immediata Cause (Final disease or condition rasulting in death) /Medical Examiner The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ok as a consequence of) Box 68760. edical Certification: To Be Completed by Physician/Medical the 9SN P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA this s after death.

if Director: After this
ad in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Colon 1 Natural 5 Pending investigation 1 Yes 2 No -4-99 2 1:00PM perforation Colonoscop 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Bon Secours To the Hospital of within 24 hours af To the Funeral Dicompletely filled in Hosportay(Certifying Physician: To the best of my impwiedge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Cartifier (Check only 29d. Data signed (Month, Day, Year) 29b. Signature an 29c. License number

State Registrar

DHMH 16 Rev 6/95

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

E

31. Date filed (Month, Day, Year)
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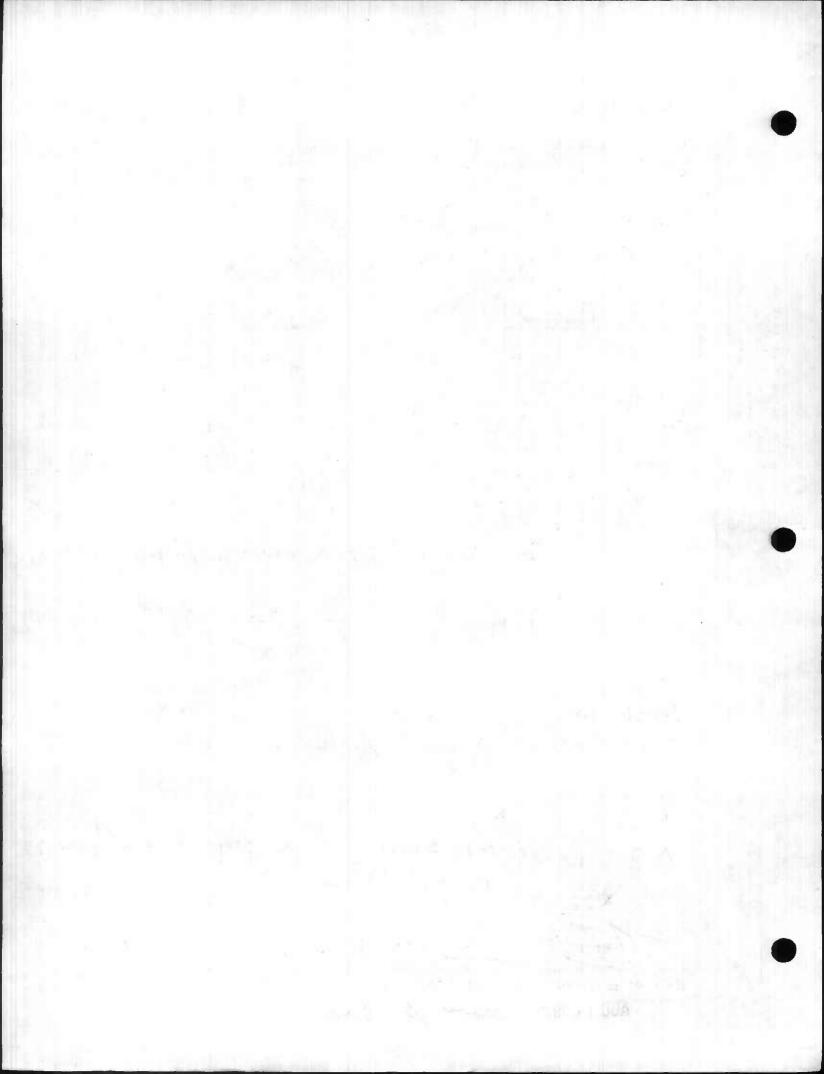
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4713 LEEDS AVE., BALTIMORE, MD.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day AUGUST 8, 1999 Physician MARY RITA RIDGE 4:30 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 419 SIXTH AVE., N.E. GLEN BURNIE ANNE ARUNDEL If Under 24 Hrs If Under 1 Ye 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M 2ØF 218-34-1271 74 Director NOV. 22, 1924 MARYLAND **Usual Residence of Decedent** 10s. State 10b. County 10c. City, Town or Location 10d Inside City Limits MARYLAND ANNE ARUNDEL GLEN BURNIE 1 Yas 2X No Director 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be r 21061 419 SIXTH AVE., N.E. UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. Pages 1 and 2 should be illed within 72 hours after of health and Mehale Hydjann.
Intil Ren 37 is newfeed other than "natural", or the Intelled of the Intelled of the Intelled of the Intelled of Intelled of Intelled Int 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE ğ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JOHN L. DOERER CARRIE P. WARSHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID WAGNER / SON 1291 AMMENDALE CT., MILLERSVILLE, MD 21108 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition AUG.12 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any Injury or ange. CROWNSVILLE MD VET. CEM. 1999 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE, MARYLAND 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** helashalu coloncancer to heres Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed es the burlei-frans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) 25 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yas 2 No 3 Probably 4 DOnknown of VItal Records, þ cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 🖾 No 1 Yes 2 No certificate al or Attending Physicien: The strends attended the history of the funeral director, pad in by the funeral director, pad in by the funeral director, page 100 pt. 25. Was case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a hin 24 hours e the Funeral D nipietely filled Pelli 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier Joetha within 2 To the comple 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) a Libuty. 1. dan 00 9559 AUGUST 9, 1999 u 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LARRY WATERBURY, M.D., 4940 EASTERN AVE., BALTIMORE, MARYLAND 21224

State Registrar 170 1999 32. Registrar's Signature

is Signature

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Deeth 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Day 1999 Month **Physician** 11:10 a.m. August 6 Charles Ruzicka Sr. ' /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street end number) Examiner Hart Heritage Assisted Retirement Living Street Harford 7. Aga (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth | Months | Days | Hours | Min. (Month, Day, Year) 9. Birthplace (State or Foreign 5. Sociel Security Number **Funeral** 1X M 2□ F Yrs. 1910 Maryland Director 220-36-9642 Usuel Residence of Dacedani with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limite 7 le marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 Yas 2 No Baltimore Baltimore Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zlp Coda 21234 1822 Trenleigh Road death 1 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Merital Status Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after a Deperment of Health and Mental Hyglene. Important: if them 27 is marked other than "naturel, or then eny injury or other traumetic event, is Medical Earth and 1 ☐ Yas 2 🕱 No If Yes, Giva Yaer or Detes: 1 Nevar Married 2 Marriad Specify: White altimore, Maryland 21215-0020 1 ☐ Yas 2 💢 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Businass/Industry 15. Decadant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elementary/Secondary (0-12) Collega (1-4or 5+) State of Maryland 12th grade Surveyor 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nema (First, Middle, Last) Louise Meyers William Joseph Ruzicka 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1822 Trenleigh Road, Baltimore, MD 21234 Carolyn A. Mech (daughter) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Nama of camatery, cramatory or other piece) 20c. Location - City or Town, Stata Bel Air Memorial Gardens 8/9/99 Bel Air 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Address of Facility 21. Signature of Funaral Sarvica Licensae Schimunek Funeral Home, Inc. 9705 Belair Road Bur a Will 23a. Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Coronary Artery Disepse Immediata Causa (Final disaasa or condition rasulting in daath) /Medical YRAYS Examiner Dua to (or as a consequence of) Examiner attending physician end for use as the buriel-transit certificate be executed Sequantially list conditions, if eny, laading to immadiata causa. Enter Undarlying Causa (Disaasa or injury that initiated avants resulting in daath) Lest Dua to (or as a consequence of) Physician/Medicai Dua to (or as a consequence of): 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying ceusa givan in Part I. 1 Yes 3 No 3 Probably 4 Unknown Records, þ Prostok Hyrestrophy 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? hes 1 ☐ Yas 2 ☐ No Division of Vital Assisted 25. Was cesa rafarrad to medicel axaminar? Be 26. Placa of Daath (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 that (Specify) Certification: To After this 28b. Tima of Injury 28d. Dascribe how injury occurred 28a. Data of injury (Month, Dey Year) 27. Mannar of Death 28c. Injury at Work? To the Hospital or Attending 6 within 24 hours after deeth.

To the Funeral Director: After 1 Natural 2 Accidant 5 Panding invastigation 1 ☐ Yas 2 ☐ No NA 6 Could not be datamined 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a, Cartifian (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signature and titla of certifian KUST 7 1999 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) AIR MD HAIL

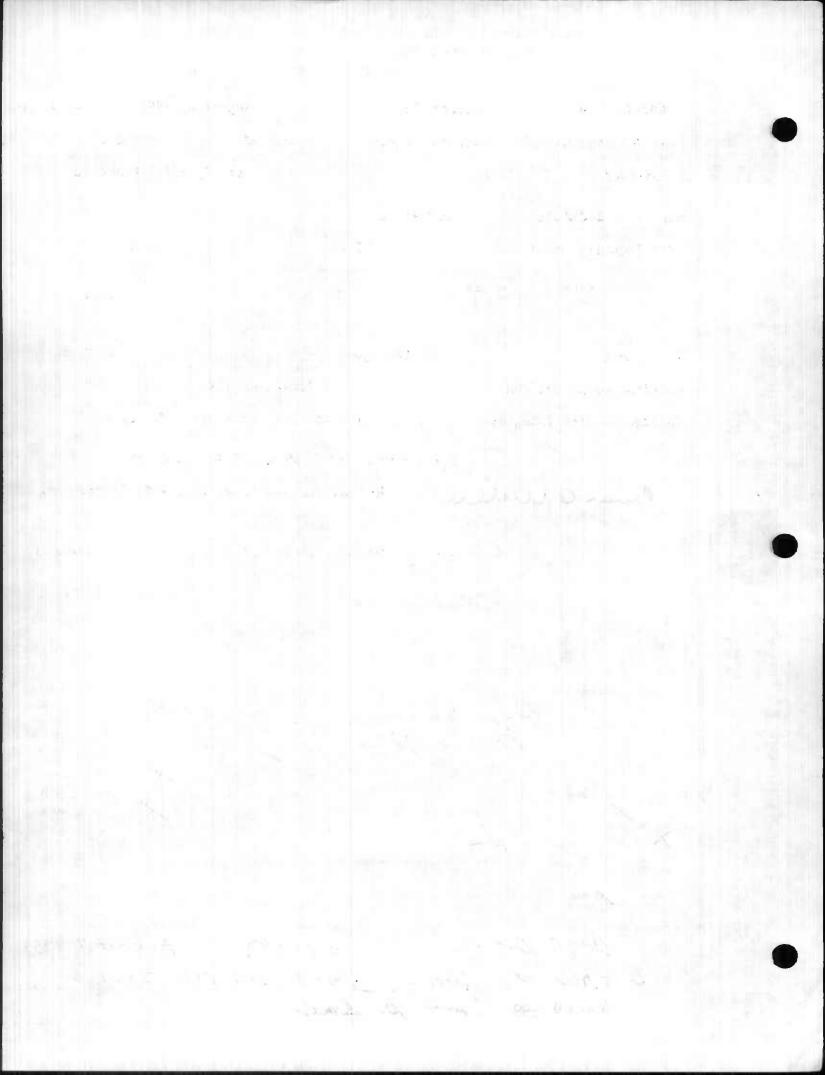
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Registrar

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31. Data fliad (Month



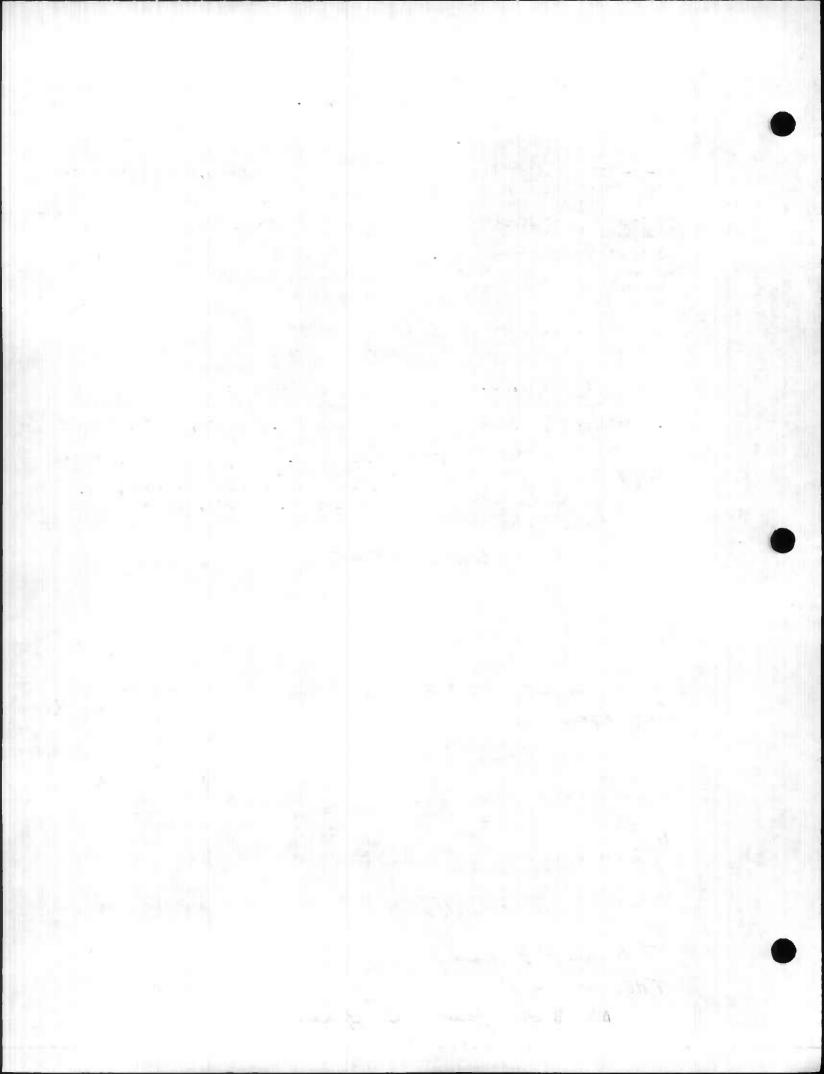
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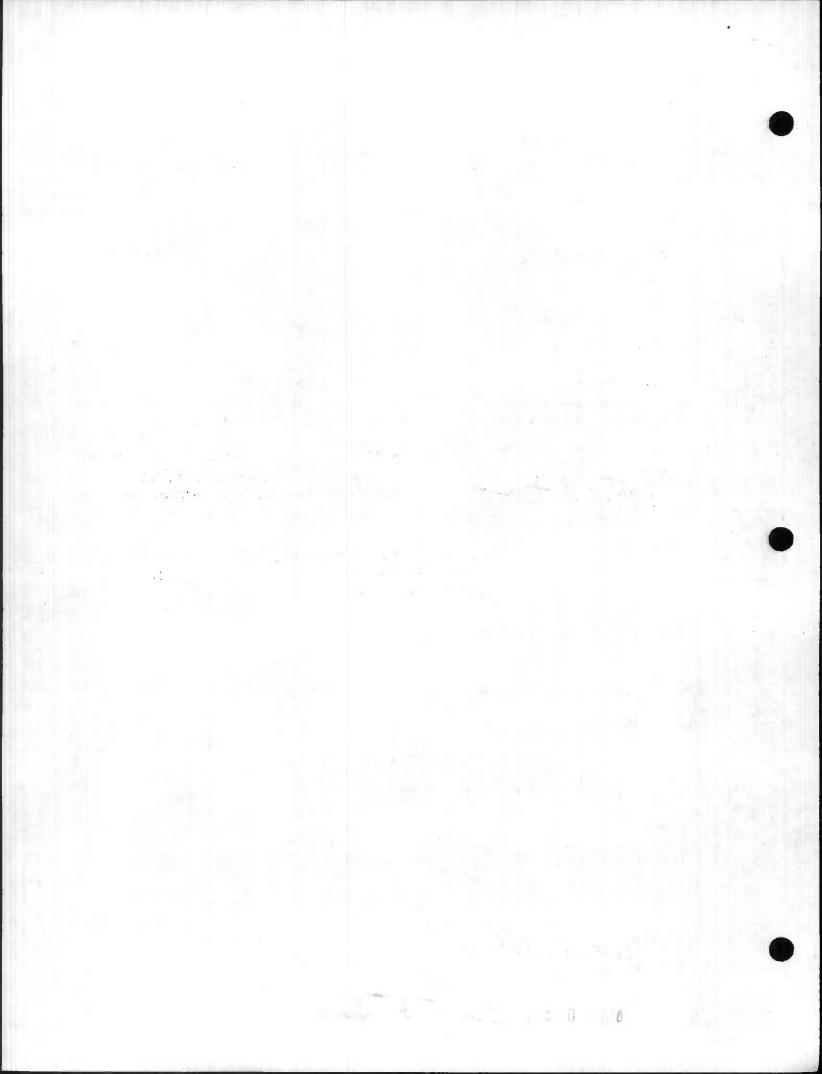
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5-0020 72 hours after death v netural', or thems 23a dicel Examiner must	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces' 1 Yes, 22 If Yes, Give Year or Dates:	Ever in U,S.	13. Was D If Yes,	ecedent of H specify Cubi s 2 13/No		(Specify Yes or No erto Rican, etc.)		State e - American I ck, White, etc.			
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Baltim permit. Pa Departmen Important any Injury ance.	4 Donation 5 Other (Specify) Hilltop Service Corp. 8/10/1999 Towson, 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland											
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death certificate be executed e attending physician and of or use as the burial-transit sician/Medical Examiner	Cause (Disease or injury that initiated events Tesulting in death) Last Due to (or as a consequence of):											
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7 3 7 8	Theoden	4. King	wy.			.M.E.		AUGUST				
State	30. Name and address of person who THEODIRE M 31. Date filled (Month, Day, Year)	iking	deeth (Item 23a)		Penn	Street,	Baltimo	re, Mary	rland 2	1201		
Registrar	AUG 10	1999	ineva	B.	Spar	K						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death August 9, 1999 Yaar **Physician** Elsie Sophia Sick 18:38 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritian Hospital Baltimore N/A If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth May 6, 1904 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Deys Months Hours 1 M 2 XF Germany 216-05-0755 Yrs Director Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or hema 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at 10d Inside City Limits MD N/A Baltimore 1 Yas 2 No Director 10f. Zip Coda 10e. Street and Number 10g, Citizen of What Country? 6527 Hilltop Avenue United States 21206 Funeral death 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours effer to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or hen page injury or other traumatic event, the page 1. 1 Never Married 2 Married specity: White 1 Yas 2 No Specify: à 3 Widowed 4 Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Hairdresser Self Employed 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumama) Be Wilhelm Schuette Marie Sagel 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Sandhill Road, Baltimore, Maryland 21221 Mrs. Pamela Savoie/Grandaughter 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from Stata Parkwood Cemetery 08/12/99 Baltimore, Maryland 4 Donation 5 Othar (Specify) 22. Nama and Addrass of Facility Leonard J. Ruck, Inc. 21. Signature of Fund Sarvice License 5305 Harford Road, Baltimore, Maryland 21214 23a. Part1. Entar the usease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart fallure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Immedieta Causa (Finat diseesa or condition rasulting In death) /Medical Chronic Obstructive Pulmonary Disease Examiner Examine Right Hip Fracture that the deeth certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediata causa. Enter Undarfying Causa (Disaasa or injury that initiated events rasulting in daath) Last Due to (or as a consequence of) Box 68760. CERTIFICATION APPROVED Physiclan/Medical Due to (or as a consequence of) 88 attending 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of deeth? P.O. 94 2 1 Yes 2 No 3 Probably 4 Unknown signed i Records, p 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed Deen 988 1 Yas 2 No 1 Yes 2 No Division of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospitel: 1 Napatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yas 2 No this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Medicai Certification: 28c. Injury at Work? After Hospital or Attending 5 Pending Invastigation Aug. 8, 1999 10:00pm 1 Netural 1 Tyes 2 No Subject Fell death. 2XXAccidant d in by the 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, fectory, office building, atc. (Specify)
Genesis Eldercare Nursing Home 24 hours after d
 Funersi Direct
letaly filled in by 4 THomicide 1801 Wentworth Road 29a. Cartifier 🛍 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and placa, and dua to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43176 August 10, 1999 m ddress of person who completed ceusa of death (Item 23a) (Type, Print) Wolf, Good Samaritan Hospital 5601 Loch Raven Blvd. Balto. Monford Α. 31. Data filed (Month, Day, Year) 32. Registrar's Signature State AUG 10

Registrar **DHMH 16 Rev 6/95**



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** no lavion /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner OME Coluces Sia TOWAYO If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7- Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1□ M 201F 75 02 07 1924 Director 213-22-1657 Maryland the Menyland 10c. City, Town or Location is 1 and 2 should be filed within 72 hours after death with the Menylen of Health and Mentel hygiene the first 23 or 28s-f show other traumatic event, in the district and other traumatic event, in the death of the maintime to notice a 10a. Stete 10b. County 10d. Inside City Limits 1 Yas 2 No Director Maryland Anne Arundel Co. Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 538 Stoney Hill Court 21113 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Neighborhood Coornatator Community Action 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Othia Oueen P Malon S. Queen 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: if item 27 is a
eny injury or other traus
page. 538 Stoney Hill Ct., Odenton, Md. 21113
20b. Place of Disposition (Name of cemetery, cremetory or other place)

Dete 20c. Location - City of Communication Communication (Name of Communication) Andrea D. Redfern/Daugther 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removel from Stete Mt. Calvary Cemetery 8/11/99 Brooklyn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral S 22. Name and Address of Escility
William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Maryland 21217 reauw Page: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 23a. Part. Enter the disc Approximete triterval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 62100 Examiner Examine attending physician and for use as the buriel-transit certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): P.O. 1 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Records, b 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? Deed hes Dage 2 : 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera After t Certification: Division 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mennar es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end manner stated. 29a, Cartifier (Check only one) 29b. Signifying and title of certified 29c. License number 29d. Date signed (Month, Dev. Year) 0 led cause of death (Item 23a) (Type, Print) 1080 Ka ON

State Registrar

31. Date filed (Month, Day, Year)

AUG 1 0 1999

DHMH 16 Rev 6/95

Registrar's Signeture

Mt. Calvar

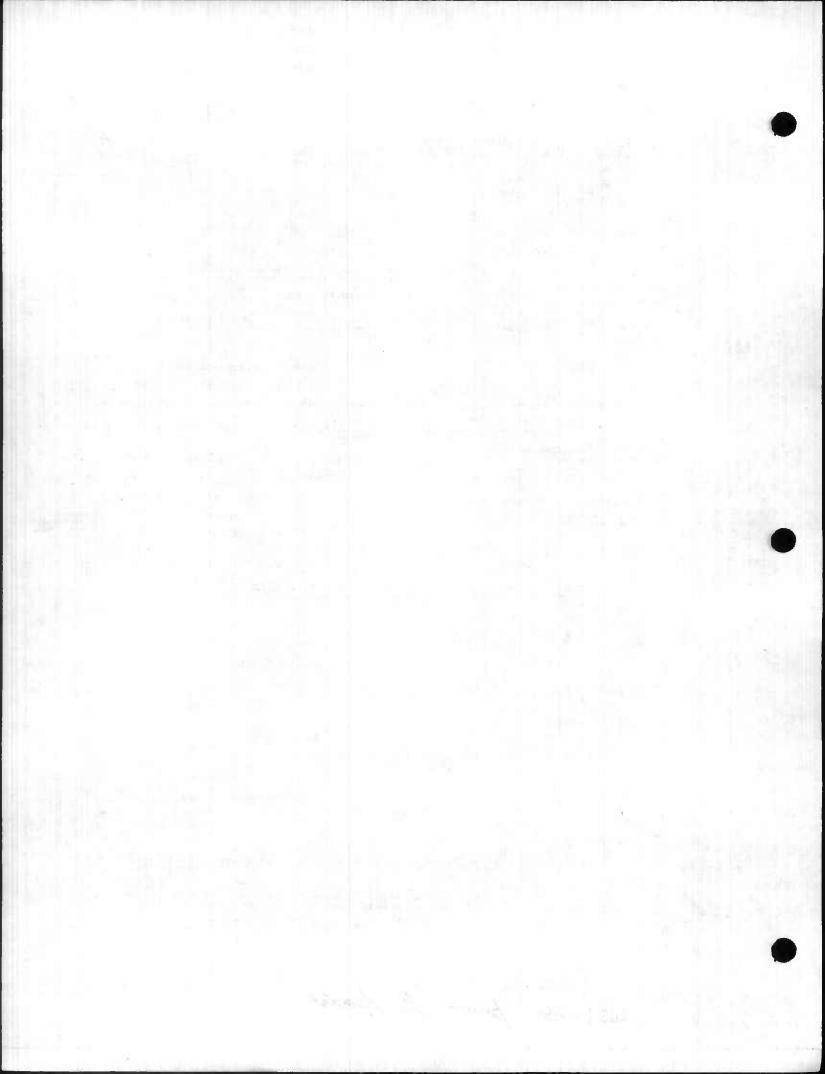
Willi 1206 1

To Markey

Phet a L DUA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month SCH RADER **Physician** 4:15 p 08 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner BATTIMORE OF MARKLAND MEDICAL STOP If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Days Months Hours 246 26 9401 76 June 10, 1923 Director North Carolina Usual Residence of Decedent the Maryland 10a Stele 10b. County 10c. City, Town or Location na 23a or 28a-f show 10d. Inside City Limits Maryland Anne Arundel **Baltimore** 1 Yes ZNNo Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 Fairfax Avenue 21225 U.S. Nema 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14 Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "instrumit, or them any Injury or other traumatic ayent, the pages." Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: P 312 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Rusiness/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Teacher Hairdressen 17. Felher's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) Champion Harvey Stanley (not available) 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick H. Schrader / Son 106 W. Hilltop Road Baltimore, Maryland 21225 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8/11/99 Baltimore, Maryland Cedar Hill Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 23a. Part 1. Enter the disease, of simplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one ceuse on each line. namurowski 4001 Ritchie Highway Baltimore, Md. 21225 Onset and Death **Physician** CAROLOMY OF ATHY /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examine physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initialed events resulting in death) Lest Box 68760. Physician/Medicai Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate has 1 Yes 1 Yes 2 No Division of Vital Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical eleisty filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Megnar of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Netural Accident 5 Pending 1 Yes 2 No investigetion 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4mms S. GREENE ST. BATTIMONE IMO 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State AUG 1 0 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 4:550m John Carlton Swain VS" 1 19 4b. City, Town, or Location of Double 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Union Memorial Hospital Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) if Under 24 Hrs. Birthplace (State or Foreign Country) Month, Day, Year) Deys Months Hours 1 MM 2□ F 219 05 1565 78 March 22, 1921 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits 1 Yes 2 □ No Maryland N/A Baltimore 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 2937 St. Paul Street 21218 U.S. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Maritai Status ☐ Yes 2X No f Yes, Give 1 Never Merried 2 ☐ Married 1 Yes 2 XNo Specify Specify: White 3 Widowed 4 Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Auditor State of Maryland 4 years 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John Swain Mary Angela Daley 19e. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Donna Hamlett Niece 1800 Little Road Glen Burnie, Maryland 21061 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State Glen Haven Memorial Park 8/7/99 4 ☐ Donetion 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signature of Funerel Service Licensee 22. Neme end Address of Feclity Gonce Funeral Home P.A. cations that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory arrest, a cause on each line. Baltimore, Md. 21225 Approximate Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) lar Tachycardia Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Lest Secono Due to (or es a consequenca of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings eveileble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? 1 ☐ Yes 2 - No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No

attending physicien and for use as the buriel-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ed by the a signed b page 2 s certificate Hospital or Attending Physician: 24 hours aftar death. Funeral Director: After this certifica director, funeral filled in by

Physician /Medicai

Examiner

Examiner

Physician

Examiner

Funeral

Director

/Medical

Director

Funeral

p

Completed

Be

Physician/Medical by Completed Be 2 Certification: 1 Naturel

25. Wes case referred to medical 1 Yes 2 No 27. Manner of Death 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

29b. Signature and title of cartifier

29d. Date signed (Month, Dey, Year) 29c. License number

moress of person who completed cause of death (Item 23a) (Type, Print)

N SM une 31. Dete filed (Month, Day, Yeer)

State Registrar

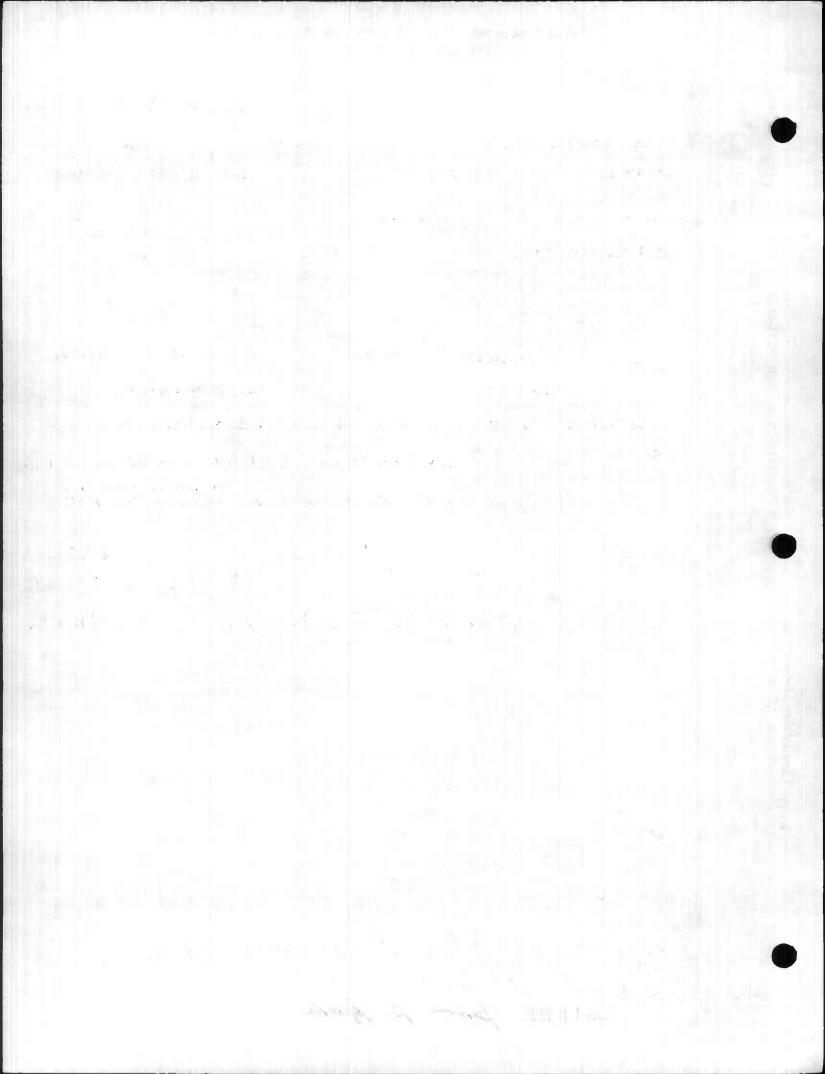
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32. Registrer's Signature

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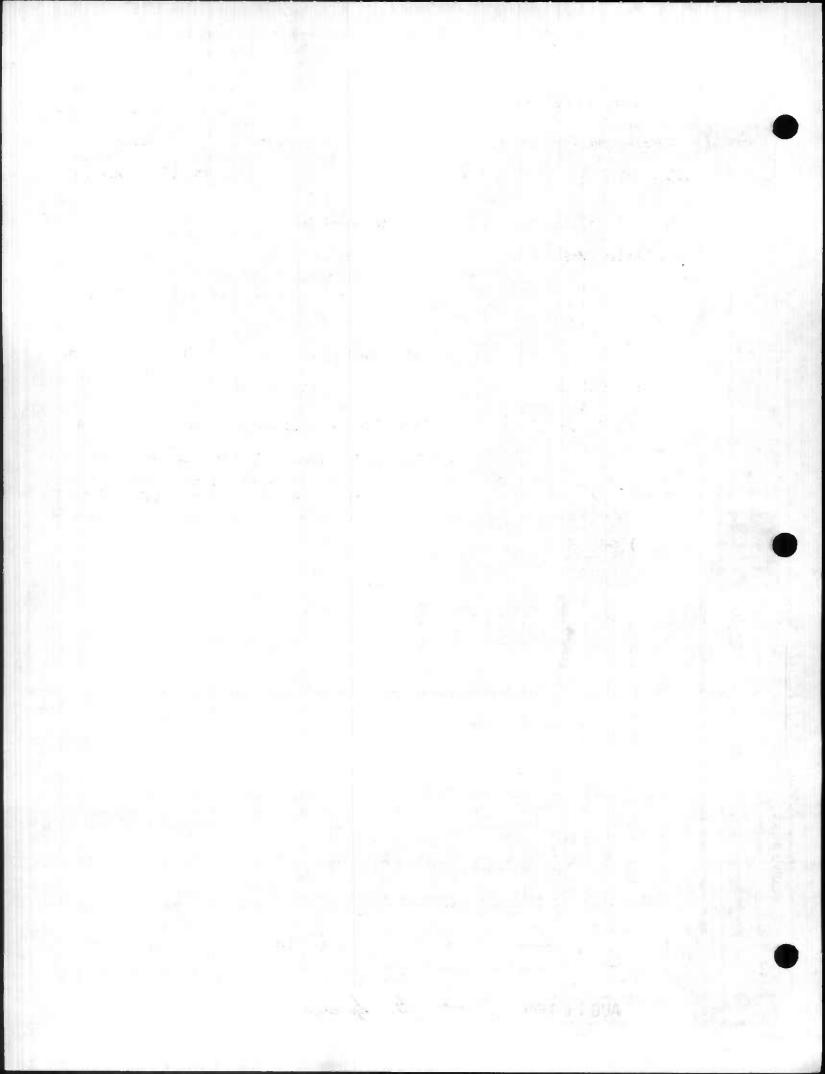
To the Hospital of within 24 hours a To the Funeral Completely filled



State of Maryland / Department of Health and Mental Hygiene | 9

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month Day Abbie Marie Sullivan **Physician** 5, 1999 9:33 PM August /Medical 4b. City, Town, or Location of Daath 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Charlestown Care Center Catonsville Baltimore H Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year)
Dec. 15, 1 5. Social Sacurity Number If Under 1 Year 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 M 2 KF Days 91 Yrs. 218-36-7811 1907 Maryland Director Usuel Rasidance of Dacedant 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiena.

Em 27 ia marked other than "natural", or itama 23a or 28a-1 show ther traumatic event, the Med cal Examiner must be notified as 1 ☐ Yes 2 ₺ No Director Baltimore Catonsville 10a. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? 709 Maiden Choice Lane 21228 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amarlcen Indian, Bleck, Whita, atc. 11. Maritel Stelus 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dalas: 1 Navar Marriad 2 Marriad Baltimore, Maryland 21215-0020 White 1 ☐ Yas 2 ☑ No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Spacify only highast grade complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Deputy Comptroller State of Maryland 18. Mothar's Nama (First, Middla, Maldan Sumama) 17. Fathar's Nema (First, Middla, Last) Anne Flynn Patrick Sullivan 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Pages 1 end 2 ment of Health eant: If Itam 27 is ury or other tra 7103 Charles Spring Way, Baltimore, MD 21204 J. Norris Byrnes (Nephew) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cramation 3 Ramoval from Stata 8/9/99 Baltimore, Maryland New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Spacify) 22. Nama and Addrass of Fecility Witzke Funeral Homes, Inc. 21. Signatura of Funeral Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Entar the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Onset end Death **Physician** /Medical Immediata Causa (Final disaesa or condition resulting in death) neumonia Examiner Due to (or es a consequence of) Physician/Medical Examiner physician and the burial-trensit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury Due to (or as e consequance of): that initiated events rasulting in daath) Last Due to (or as e consequance of): 80 attending p for usa es ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Wes en autopsy performed? 1 Yas ZONo 1 ☐ Yes 2 ☐ No certificata Attending Physician: funeral director, Be 25. Was case rafarrad to medical 26. Place of Death (Check only ona) Othar: Nursing Homa 5 Assidance 6 Other (Specify) 1 Yas 2 KNo Division of Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding Invastigation 1. Natural i or Attendin after death. Director: Aft 1 Yas 2 No 2 Accidant 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Piece of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 1 24 hours after the Funeral Directles of Funeral D 4 Homicida Hospital Medicai 29a. Cartiflar 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. To the Fund (Check only one) 2 Medical Examiner: On the besis of examination end/or invastigetion, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner stated. To the within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signatura end titla of certifier MD choice care Caterral onythe 30. Name and addition of person who completed cause of death (Item 23a) (Type, Print) Msider vois ~ [451 14 32. Registrar's Signatura State 1999 ner Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Starkey C. Rose 6,20 P.m. Augus /Medical 4a Fscility Name (If not institution, giva street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** Rosedale BAIIMORE
If Under 24 Hrs. 8. Date of Birth
Hours Min. Feb. 23, Yang 18
Many Tand HospilAl FRANKLI'N SQUARE 5. Social Security Number 0 6. Sex CenTer If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2√2 F 212-09-7477 81 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ₩ Yas 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 U.S. of America 6726 Brentwood Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Mail Clerk 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Catherine Gaff Cavaliere David 2 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Rosemary Starkey (Daughter) 6726 Brentwood Ave. Balto., Md. 21222 20b. Place of Disposition (Nama of commatery, cramatory or other place)
St' Stanislaus 20c. Location - City or Town, State 20a Method of Disposition August 1 Burial 2 □ Cremation 3 □ Ramoval from Stata 11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
W. Dabrowski-Chojnacki F.H.'s P.A. 21. Signature of Fungal Service 1005 Dundalk Ave. Balto., Md. 23a. Part Ente callions that o used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Batween Onset and Death **Physician** /Medical immediate Cause (Final disaasa or condition resulting in death) Examiner Examiner 5 VEARS 1 ension Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medicei examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Unpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier

be executed P.O. Box 68760 Records, Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this centifica completely filled in by the funeral director,

signed by t

28a-f show

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Rems 23s

"natural", or

and Mental Hygiene.

Health and Mental

Department of Health a Important: if Itam 27 is any Injury or other tra

altimore, Maryland 21215-0020

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State Registrar 29b. Signature and title of certifie

RITA

29c. License number

oaks

lin Square DR. BAITIMORE, MARYLAND

29d. Date signed (Month, Day, Year)

and manner stated.

9000

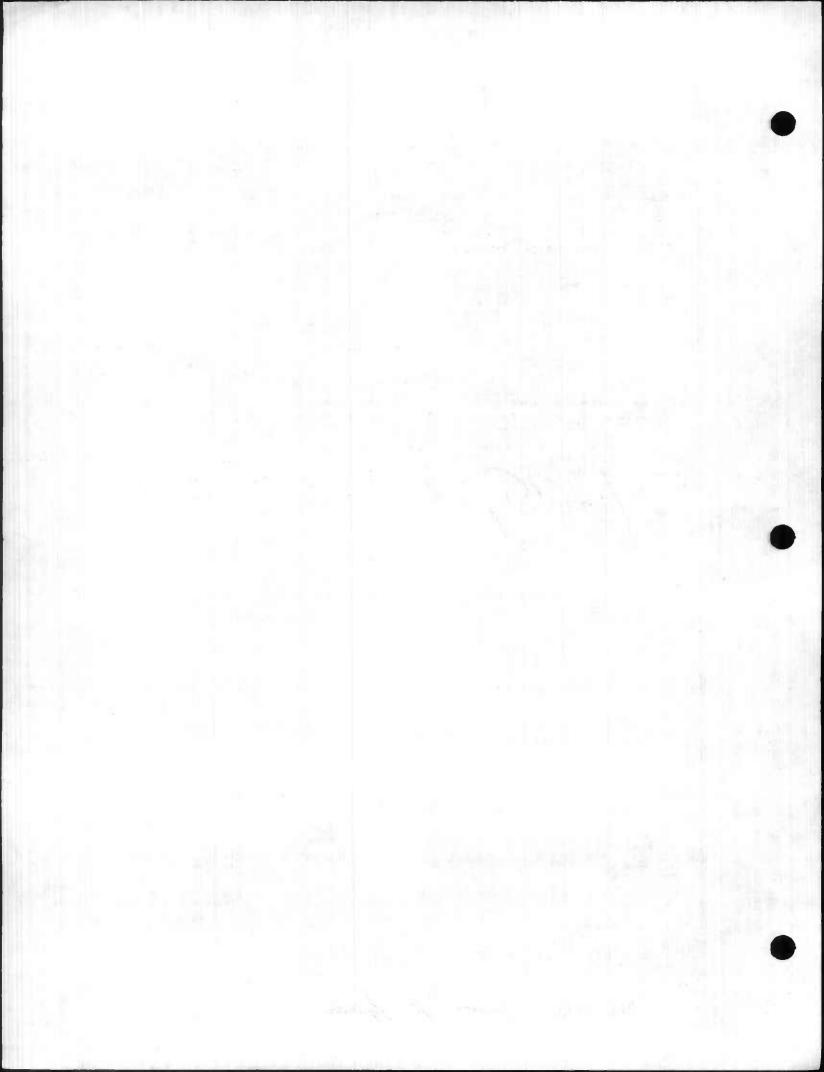
FRANK

32 Registrar's Signature

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

MATHUR

AUG 1 0 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Des Month Veer Physician Catherine E. Tubbs 10:50 A.M. 6 1999 August /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Emmanuel House Elkridge If Under 24 Hrs If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Hours Months 1 M 200 F 215 07 8581 94 Director April 8, 1905 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Maryland N/A Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3825 St. Margaret Street 21225 U.S. Berns 23a 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Detes: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 Never Married 2 Merried Maryland 21215-0020 "natural", or 1 Yes 2K No Specify: Specify: p 3X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene."n Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If Nem 27 is marked offer any Injury or other transfeed offer. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 2 George Huebler Anna Denhart 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) August Santesse 801 Streambank Court Towson, Maryland 21286 Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/9/99 Holy Cross Cemetery Baltimore, Maryland 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. ramerous tions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, as cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examine attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760. Physician/Medicai Due to (or as e consequence of) 88 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown igned by sleapangi of Vital Records, þ 2 24b. Were autopsy findings 24a. Wes an autopsy performed? Completed available prior to completion of cause of death? has 1 Yes 2 No 1 Yes 2 No 8 25. Was case referred to medical 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Group home 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 7 After this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Menner of Death Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Matural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide edicai 1 Dertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29e. Certifier and menner steted. 29b. Signeture and tills of conflict 29c. License number 29d. Dete signed (Month, Day, Year) dress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar mi

Month, Day, Year)
AUG 1 0 1999

10

Registrer's Signeture

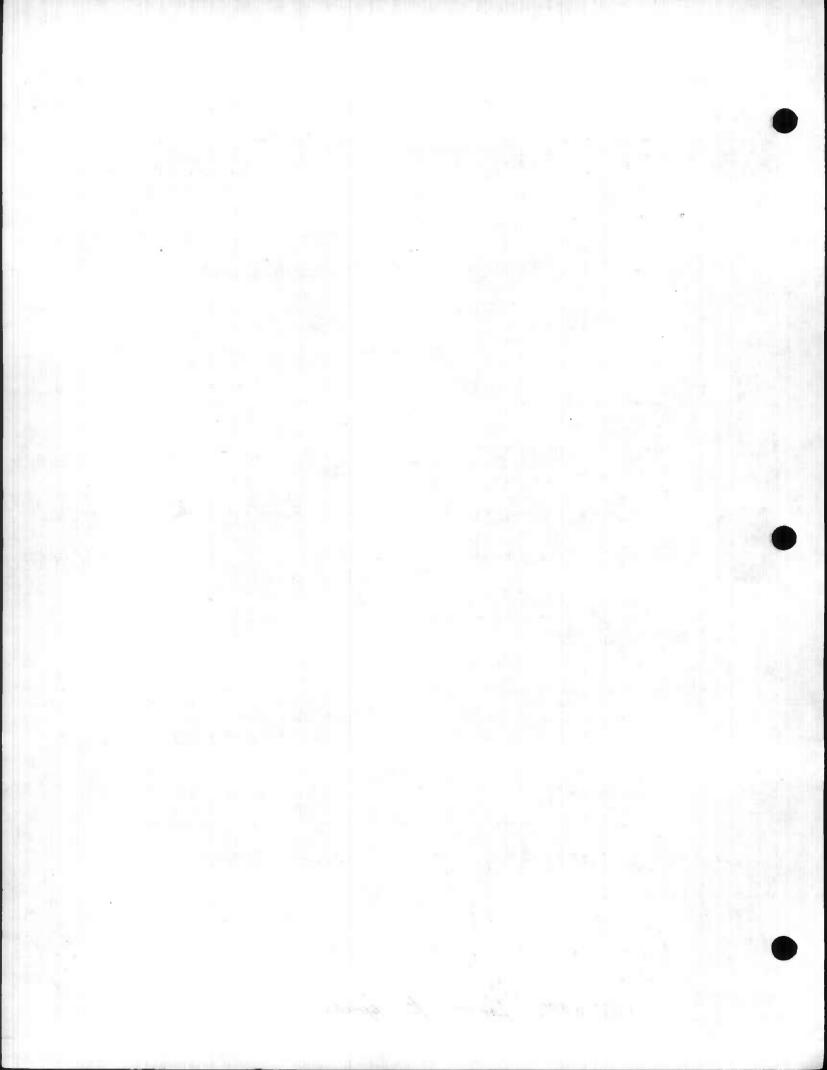
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31. Date filed (Month,

DHMH 16 Rav 6/95

Hennington &

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				Cer	titicate	OI L	Calli		He	g. No.			
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Funeral Director	218-42-2614	Sax 1∏M 2□ F	7. Aga (In yrs. lest birthdey) If Undar 1 Year If Under 24 Hrs. 18. Dete of Birth (Month, Day, Year) The state of Birth (Month, Day, Year) The state of Birth (Month, Day, Year) The state of Birth (Month, Day, Year)						^{Yaer)} 1944	9. Birthplace (Steta or Foreign Country) PENNSYLVANIA		Foreign A	
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th with the Ma 23a or 28a-1s at be notified	10e. Street and Number 28 VISTA A	VE.			10f. Zip Co	ode 2106	1		10	og. Citizen of UNITE	What Coul		
be filed within 72 hours efter death with the Maryland tal Hygiana. d other than "naturel", or items 23a or 28e-f show event, the Medical Examinar must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married	12. Was Decedent Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	7 1961-		Vas Dacedar Yes, specify ☐ Yes 2		spanic Ori n, Mexicen Specify:	igln? (Speci n, Puerto Ri	ty Yas or No- can, etc.)		eck, White,	ce - Amarican Indian, ck, White, etc. y: WHITE	
5 5	15. Decedent's (Spacify only highast g Elementary/Secondary (0-12) 12		5+)	16a. Decedent's Usuel Occupation (Give kind of work done during most of workin life. DO NOT use retired) WIRE ROPE SPLICER					rking		Businass/in		
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tra tr	19a. fnforment's Name/Reletionship NICOLLE M. TISHU								Route Number, NIE, MD			Code)	
00-2	20a. Method of Disposition 1XDBuriel 2 Cremation 3 4 Donation 5 Other (Special		cemet	ery, crem	sition (Neme etory or othe GE MEN	er place	,		Pata 2	ELKR	City or To		
permit. Peg Department Important: H any Injury o	21. Signature of Funeral Service Licensee KIRKLEY - RUDDICK' FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061												
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/Medical Examiner	fmmediate Ceuse (Final disaase or condition resulting in deeth)	· MATA	Due to (or es			CA-	RUN	10M	+-		1	" MON"	TH
axecuted on and ital-transit	Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause, Disease or injury	b	Due to (or as	consequ	uence of):	-							
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Physician: The ritis cardificata aral director, page Co	25. Wes case referred to medical examiner?						26. Place	of Deeth	Check only on	e)			
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the Line	27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not		ay Year) 28b	Time of tnjury	M 280	fnjury Work	et ? Yes 2 🗆	No	ld. Describe ho				
urs after death. ral Director: A lied in by tha fi	4 Homicide determine	d 289. Place of in building, e	ijury - At home, itc. (Specify)						of. Location (St. City or Town	, State)			er,
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To the Hospital within 24 hours a To the Funeral I complately filled	Crief	and manner s	tated.							9d. Date sign			

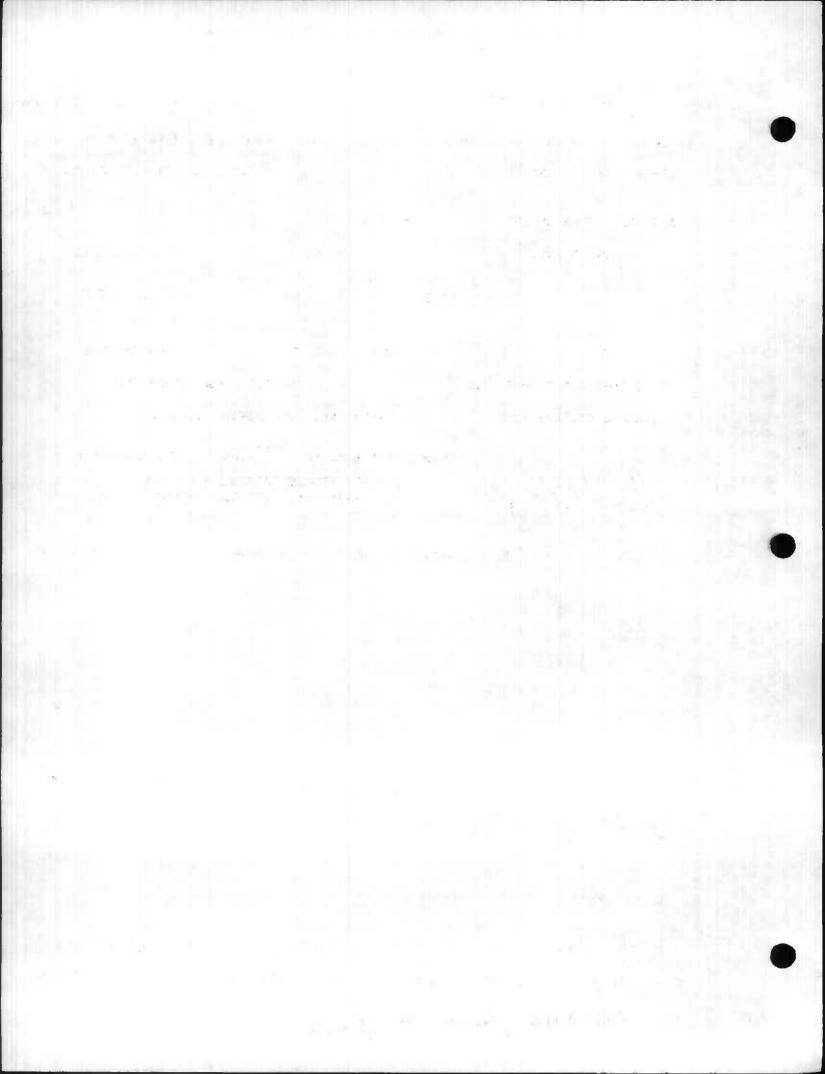
State Registrar 31. Dete fited (Month, Dey, Yeer) 32. Registrar's Signature

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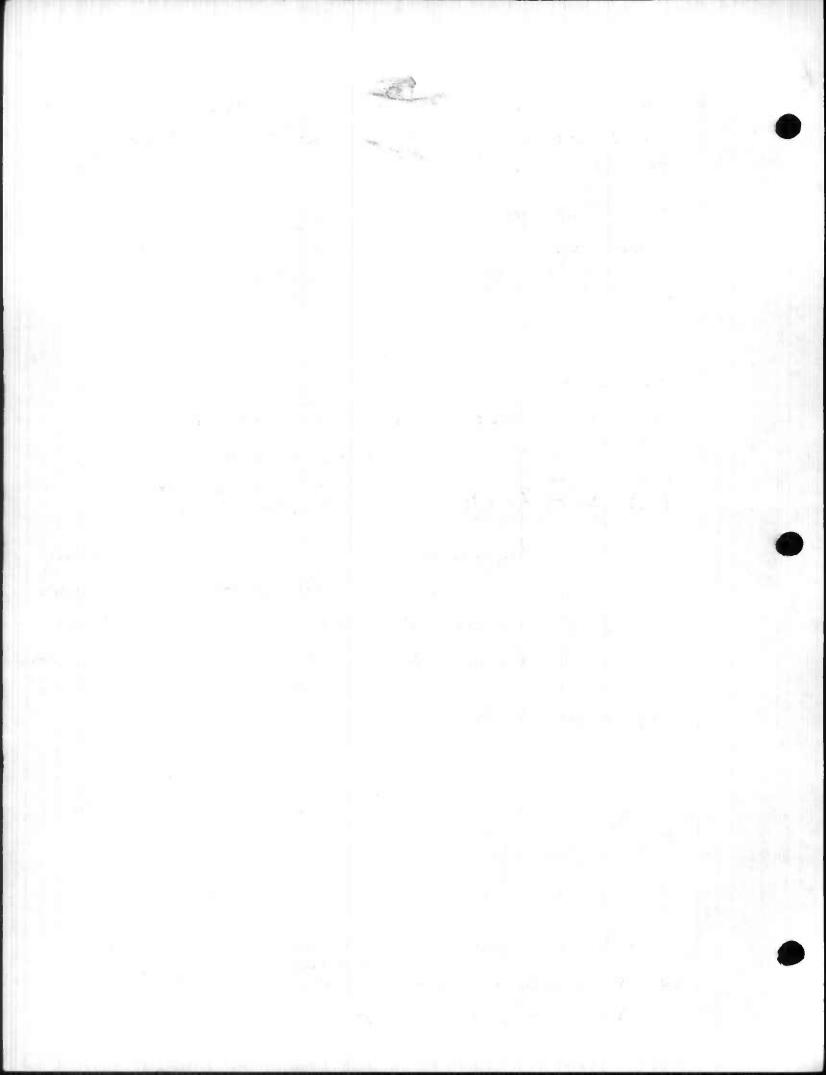
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GRADY TISHUR



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 25064

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/Medic	al	Edna	At	Α.	·.	Thompson		41 Oh T.		8,1999		6:10 ar
Examir	ier	4e. Fecility Neme (If not institu Franklin Wo						4b. City, Town, or Rosedal	2	Balt	y of Deeth imore	
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23a or 28	ral Director	10e. Street end Number 628 George A	lve.			10f. Z	ip Code 2	1221		10g. Citizen of US		try?
naturel, or items 23s or 28s-f ehow	by Funeral	11. Meritel Stetus 1 Never Merried 2 M 3 Widowed 4 Divorce	larried	Was Decedent Endemed Forces? 1 ☐ Yes 2 ☑ Note of Yes, Give Yeer or Detes:				lispanic Origin? (S en, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	Speci	ce - America ck, White, e fy: Wh:	
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and a m		19e. Informent's Neme/Relation Margaret McNa				19b. Mailing Addre		end Number or Ri Le Ave. I			1237	Code)
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Department of Her Important: If Itam any injury or other once.		21. Signature of Funeral Service	ce Licansee	7.00x			Cvac	ss of Fecility ch/Roseda			_	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Allen LERRU -ARRU /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** BALLIMORE HOSPITAL GUA MARIS @ MERCON If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 54 Months 10 M 20 F Days 219-40-7201 Director Jan. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 No FINKSBURO arro Directo m 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2005 HEADIAN SRIVE 21048 AZCI Funeral Items 2 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status troumstic event, the Madical Examiner Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Blac ò If Yes, Give Yeer or Detes Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiane. Elementary/Secondery (0-12) College (1-4or 5+) Dalto . Cutu Delatol tublic Wks 10+h NA 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Department of Health and Mental I mportant: If item 27 is marked or allev illiam TERRU Mable 19a. Intorment's Name/Reletionship (Type, Print 19b. Mailing Address (Street end Number or Rural Route Number, City Town, State, Zip Code) Md ARabian 2005 tinksburo CHONNEM. TERRY -Wite other t 20b. Place of Disposition (Name of cemetery, crefinetory or other) altimore. 20a Method of Disposition Dete n - City or Town, State 1 Buriai 2 ☐ Cremetion 3 ☐ Removal trom State Injury or 8.10.99 Landall 4 ☐ Donation 5 ☐ Other (Specify) remorial Yark 22. Name and Address of Facility 21. Signature of Funerel Servica Licensee asela1 RCh 0 TOUR Hue 21215 4300 Wabash Pat1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, sheck, or head/failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tustate Prostate /Medical Immediate Cause (Final Cunus disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the bunal-transit Sequentielly list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or as a consequence ot): certificata be axec Physician/Medicai the Due to (or as a consequence ot): 98 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by I 1□ Yes 2 No 3 Probably 4 Unknown by 24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of deeth? 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) N 35 pt 4 1 Yes 22 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Manuer of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Naturel after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, tactory, office building, etc. (Specify) 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours a 29a. Certifier Certifying Physicfan: To the best of my knowledge, deeth occurred at the tima, date and piece, and due to the course(s) and menner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piaca, and due to the cause(s) and menner stated. Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the cause(s) and manner as stated (Check only one) within 2 To the F 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 0 D 40854 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultiner, MD 21202 30L SI MD

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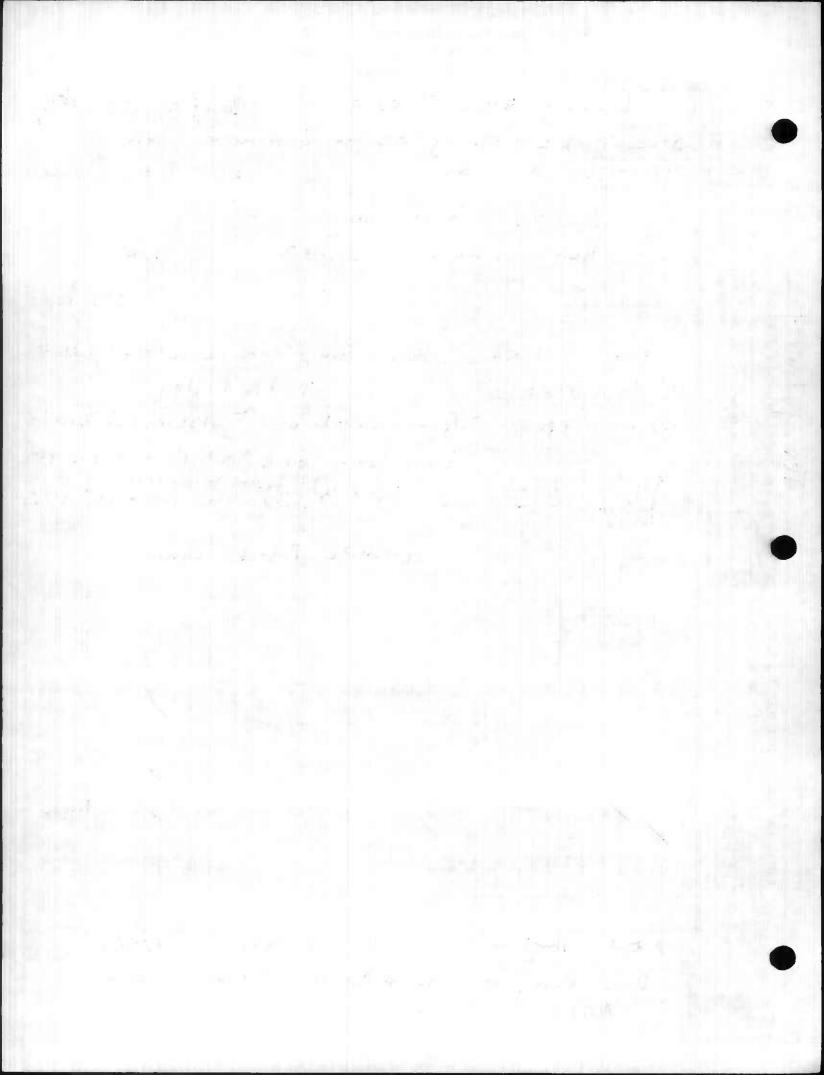
State Registrar

DHMH 16 Ray 6/95

Dete tiled (Month Dey, Year) AUG 1 0 32. Registrar's Signature

3. Sports

A-- A



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Deeth 3. Time of Death

1999

7:02 am

MD 21401

August

Physician
* /Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anina Elizabeth Trott

Director the Maryland worde . With

death permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other treumatic even.

altimore, Maryland 21215-0020

Physician /Medical Examiner

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P.O. Box 68760,

Division of Vital

certificate be executed Attending Physician: death. after death Director: To the Hospital or within 24 hours aft To the Funeral Di completely filled it

4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Hours Min. Nov. 26, 1916 If Under 1 Year 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□ M 2☑ F Months Virgin Islands 215-24-6495 82 Usuel Residence of Decedant 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County rthan "natural", or items 23a or 28a-f ehov the Medical Examiner must be nothed at 1 Yes 2 No Director MD Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? Funeral 3 Alder Road 21403 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Neils C.A. Kjeldsen Alice Rose Gonzels 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Carlene Curry (Daughter) 7421 Longmont Lane, Port Charlotte, FL 33981 20a. Method of Disposition 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Ramoval from State Sherbert Family Cemetery 08/11 Deale, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401
Do not enter the mode of dying, such as cardiac or respiratory arrest,
Appro Approximate Interval Between Onsat and Death Immediete Ceuse (Finel c disaasa or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yee 2 No 3 Probably neumonia þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy NOWM ure cellulitis 1 ☐ Yes 2 No tacia 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Menner of Death Lo 1 Inpatient 2 ER/Outpatient 3 DOA 28c. tnjury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Naturet 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete and piace, and due to the ceuse(s) end menner as stated.

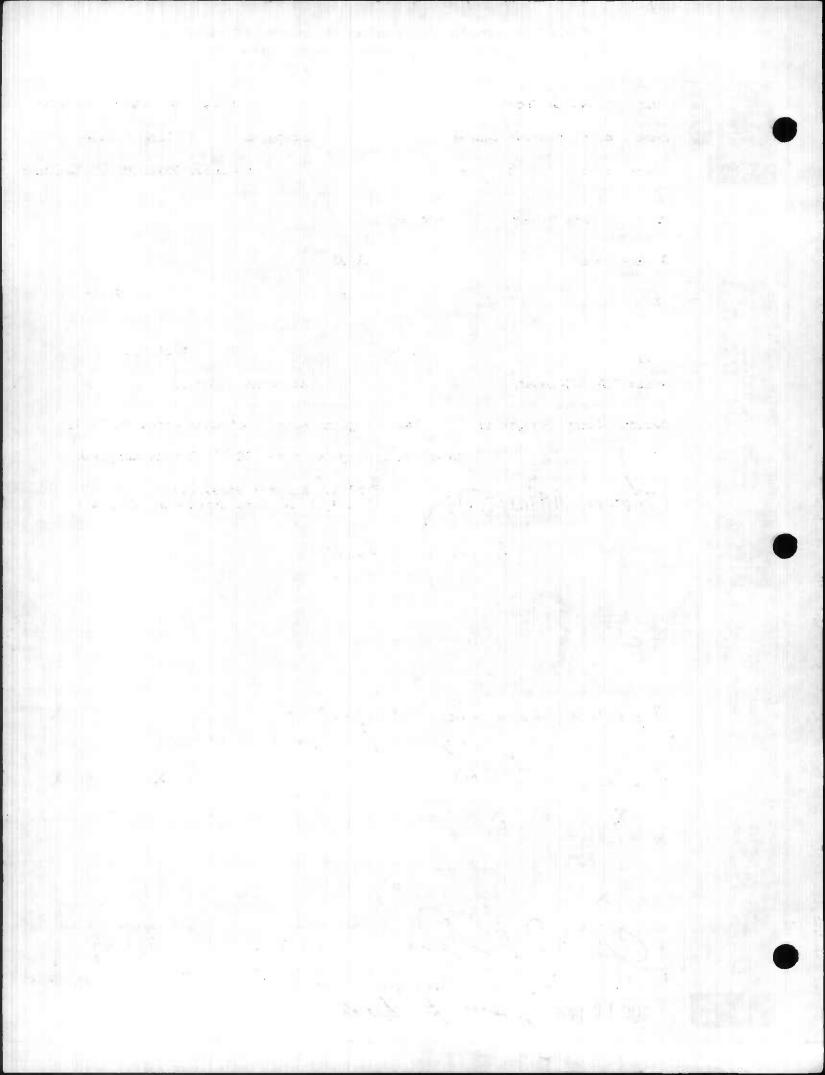
Z Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manufact at the time, determined to the cause(s). edicai 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and sittle by o D41816 64 Franklin Annapolis M 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print) Avunde/ Medica/ Center

MD 105

32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) AUG 1 0 199



Piease Type or Print in Biack indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month August Harry Preston Vick 1:30 gm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Rosedale 05 Square tranklin O, ta 0 Hours Min. Applied 29,1919 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1 M 2 F Months Days 217-09-0780 79 Baltimore, Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Sipple Avenue 21236 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 [X]Yas 2 □ No If Yes, Give Yeer or Detes: WW Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) NA Elementery/Secondary (0-12) Design Engineer Crown, Cork & Seal 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Unknown Margaret Unknown 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryant D. Vick (Son) 24 Leslie Avenue Baltimore, Maryland 21236 of Disposition (Name of Dete 20c. Location 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriat 2 Cremetion 3 Removel from State Gardens of Faith Cem. August 9, 1999 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licenses 22. Nema and Address of Fecility Lassahn Funeral Home Inc. 23e. Part. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) ears Due to (or as a consequence of): tensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Dua to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat examiner? 26. Placa of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

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Physician

/Medical

Examiner

Funeral

Director

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d other than "natural", or items 23s or event, the Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or fem
any Injury or other traumatic event, the Market Exercises

Physician /Medical

Examiner

Physician/Medical Examiner

Completed by

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29e. Certifier

(Check only one)

29b. Signature and title of certifies

Thomas F.

USO AS

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

State Registrar

DHMH 16 Rev 6/95

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30. Native and address of person who complete

32. Registrar's Signature

id sause of death (Item 23a) (Type, Print)

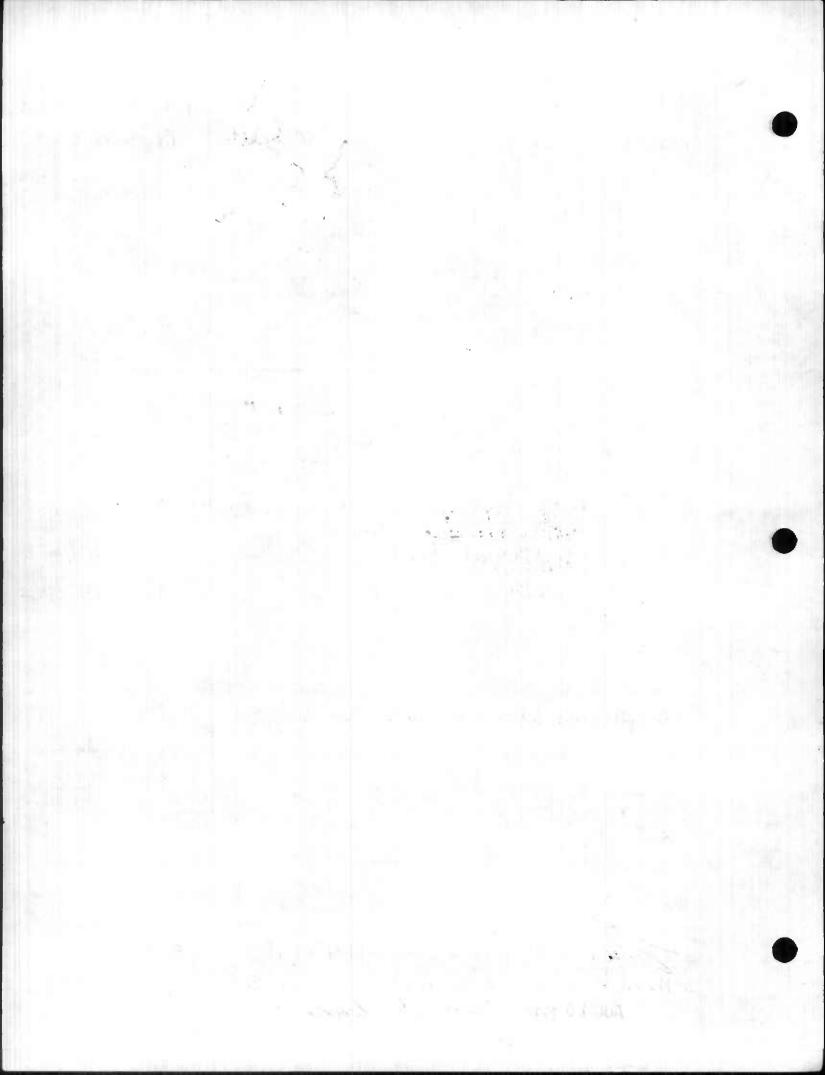
9000 Franklin Square Drive Baltimore, md

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

29c. License number

29d. Dete signed (Month; Day, Year)



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Division of Vital Records, P.O. Box 68760, VANTZ, RUOSA BELLE To the Hospital or Atterwithin 24 hours after des To the Funeral Director complately filled in by th

Baltimore, Maryland 21215-0020

State Registrar 29b. Signature and title of certifier

31. Date filed (Month Day, Year)

32. Registrar's Signature

à Kutner-Sand, no

29c. Licansa number

047451

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

8/2/99

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print)

Cynthia Kuthner-Sands, mo 11110 Medical Campus Road Suite 130

DHMH 16 Rev 6/95

Name assets Rad in process Astronomy para pagaint THE PARTY OF THE P

Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 4.20 An **Physician** CHARLE 4a Facility Name (If not Institution, give street and number) 22-5 /Medical ATHOLAN 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 212 KNOLI N. ItamE BALTIM DE. IRVING TON If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-40-7847 1 M 2□ F Months Director Usuel Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic avent, the Medical Examinar mats be notified at MC 1 Xes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21218 5. 712 street Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Race - American Indian, 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 ia marked other than °1 any injury or other traumatic avent, the Mental Injury or other traumatic avent, the Men Elements ry/Secondery (0-12) College (1-4or 5+) BAKERU 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be MAC VICGINIA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STREET 20 Baltimore E. DACBACA 20a. Method of Disposition

1 Buriel 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 4 □ Donetion 3 □ Other (Specify) Cemeter re of Furieral Service Licensee 21. Signatu 22. Name and Address of Fecility. Beffs Funera Caroline 21213 ud. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Fine) disease or condition resulting In deeth) Examiner lician end burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dun to (or es e consequence of) attending physician for use as the buna Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably W Unknown þ 24b. Were autopsy findings evailable prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 200 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 | Inpatient 2 | ER/Outpatient 3 | DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred ne Hospital or Attanding Pl n 24 hours after death. ne Funeral Diractor: After th 28b. Time of 28c. Injury at Work? Certification: : After ! 1.2 Neturel 5 Pending Investigation 1 Tyes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner steted. Medical completely To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registrare Signature

State of Maryland / Department of Health and Mental Hygiene

	Certificate of D	eatn
Decedent's Name (First, Middle, Last)	11111	~
Physician Willie Willie	Williams	JR
Examiner 4e Facility Name (If not institution, give street end number)	4b	. City, Town,

Funeral

Director

Phy

with the Maryland death should be filed within 72 hours after ond Mental Hygiene.

marked other than "naturel", or ite

7 is marked other than "naturel", or flems 23s or 28s-f show treumatic event, the Medical Examinations to a nominal statement.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fem 27 is marked othe any Injury or other treumatic event, bridge.

Physician /Medical Examiner

and I-transit The law requires that the death certificate be executed physician ar for usa as detached signed by t been si ils certificate has b

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: 24 hours aftar death.
Funeral Director: After this certifica stell filled in by the funeral director. g To the Hospital or within 24 hours aft To the Funeral Di completely filled in

3. Time of Death 2. Dete of Deeth Day AUGUST 06 1999 01:14AM or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL
5. Social Security Number 6. Sex 7 A BALTIMORE CITY N/A If Under 1 Year Birthpiece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) 1⊠X 2□ F Months Hours Min. 42 Yrs. 216-78-8403 FEB 22 1957 SOUTH CAROLINA Usual Residence of Deceden 10e. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits ¥Yes 2□No Directo MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 MCCULLOH STREET U.S.A. Funeral 21217 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Merried 1 ☐ Yes 2 ☒ No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JANITORIAL. CUSTODIAN 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) WILLIE WILLIAMS SR LULA MITCHELL 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Lula Mitchell/Mother 1700 McCulloh Street, Baltimore, Maryland 21217 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, Stete XXBurial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) DRUIDRIDGE CEMETERY 8-11-99 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licanson 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Acquired Immunodeficiency Syndrome two years disease or condition resulting in deeth) Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca of) Physician/Medicai Due to (or as e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Grastrointestinal bleeding by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 No 10 1 Yes 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, efc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete and piece, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

29c. License number

RES-000

29d. Date signed (Month, Dey, Year) august 6, 1999

State

Johns Hopkins Hospital, Tower 110, 1001 North Wolfe St. Baltimore, Maryland 2125
31. Deterfied (Month Dex Year) 1999 32. Registrary Signature & Spouls Registrar

29b. Signature end title of certifier

Leulyn K Scott

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day 3 Yee WOLFE ALLISON JAMES 7:34aM August , 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death A / + I MORE City H Under 24 Hrs. 8. Date of Birth PI +AC N/A 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplece (Sountry) 04/26/1948 CANADA Age (In yrs. last birthday) 9. Birthplece (State or Foreign Days 12 M 2□ F 029-34-1627 51 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No WASHINGTON JOHNSON CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1609 LAKE DRIVE EXT. 37601 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yas 2 TNo Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PRESIDENT / OWNER EDWARD & ASSOCIATES 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ALLISON M. WOLFE RETA COAKLEY 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) GLORIA M. WOLFE(WIFE) 1609 LAKE DRIVE EXT. JOHNSON CITY, TN. 37601 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 MRemovel from State MONTE VISTA BURIAL PARK8/6/99 JOHNSON CITY, TN. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. Medil Nellank 4905 YORK RD. BALTO., MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) Idiopathic Dulmonary Months Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24a. Wes an autopsy parlormed? 24b. Wera autopsy tindings available prior to complation of causa of death? 1 Yes 2 No 1 Yas 2 No 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Physician/Medical Examiner physician and the buriai-transit 68760 The law requires that the death certificate be Box 080 P.O. Records. by Be Completed page of Vital Certification: To After this Division or Attending a Funeral Director: Aft history filled in by the fur filled in by

Hospital

To the

within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Director

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Completed

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parmit. Pages 1 and 2 abouid be filed within 72 hours attar Department of Neaths and Mercial Hydione. Introductant: If them 37 is merked other than "netures", or he any injury or other treumetic event, the Medical Estantion any Injury or other treumetic event, the Medical Estantion

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0020

25. Was case referred to medical 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 C Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide

(Check only one) 29b. Signeture and title of certifier

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

Cenneth C elchesk, MD 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who compléted cause of death (Item 23a) (Type, Print)

Kenneth Bilchick JHH-Tower 110

600 N. Wolfe Street Baltimore, MD 21287

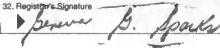
August 3,1999

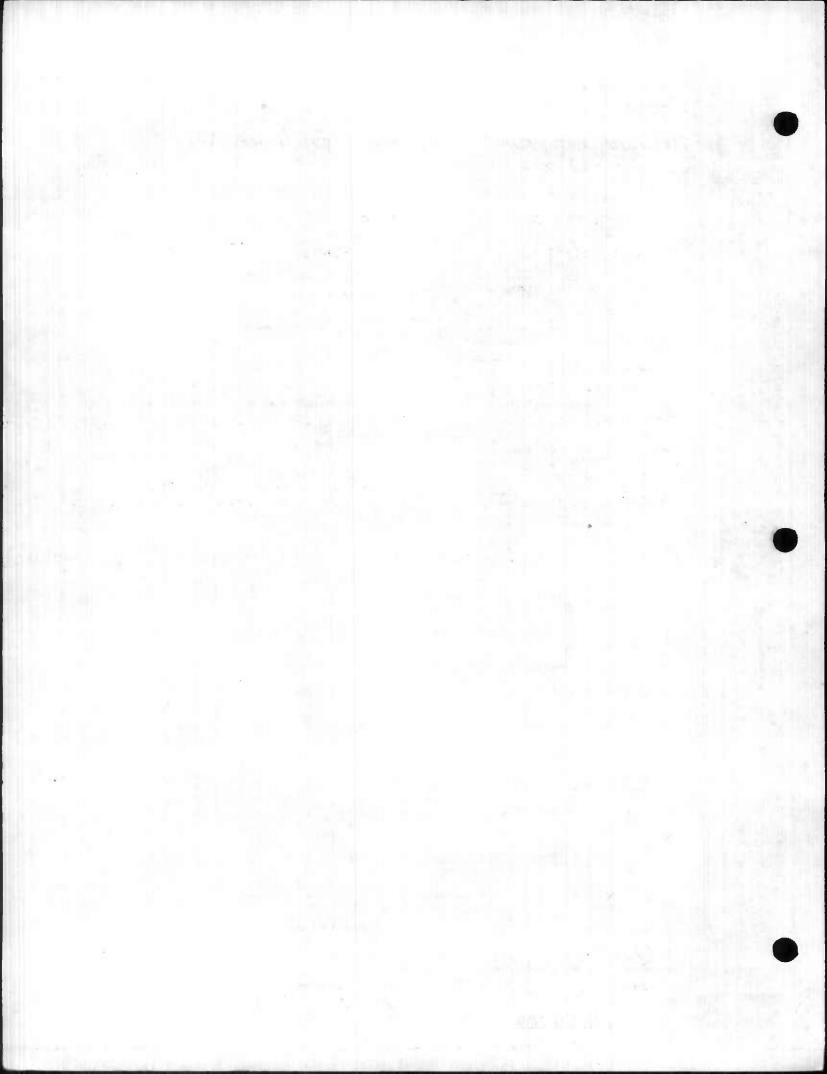
State Registrar

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DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year) AUG 1 0 1999



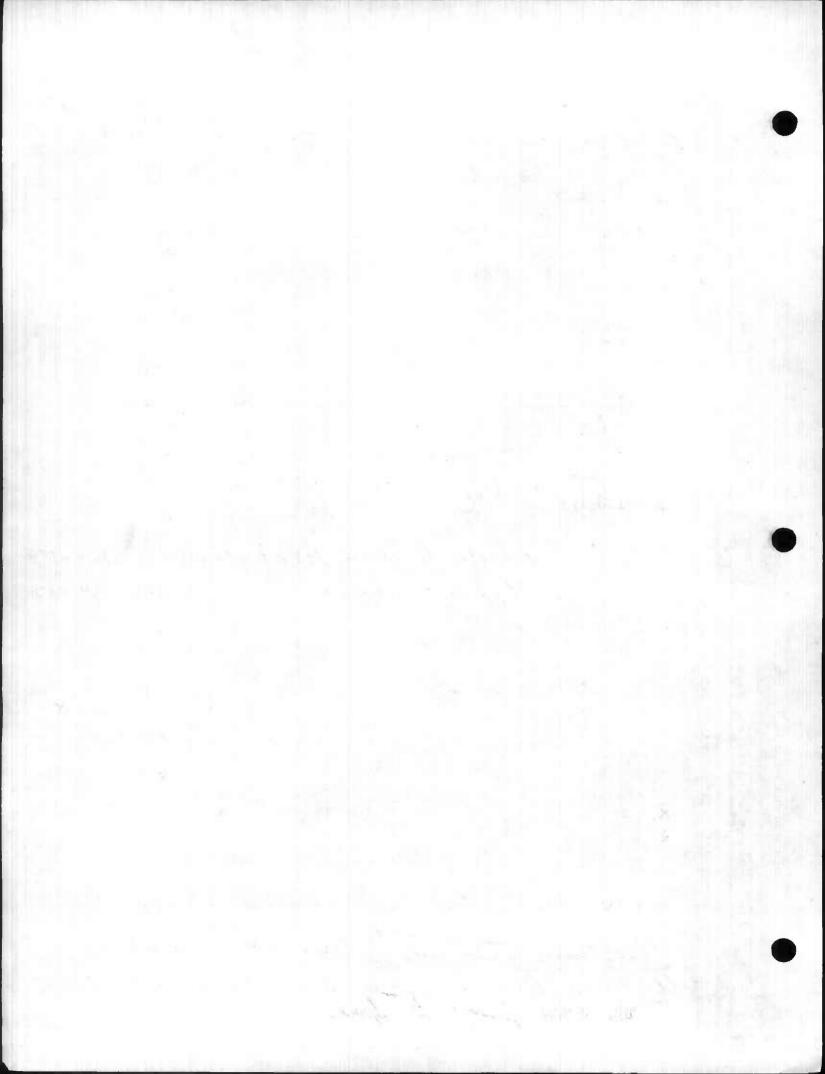


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** 1999 Linda Rose Warner August 5 7:00 pm /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Severn Severn KUN our If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) March 1, 1945 Montana 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10M 20 F Months Yes 526-74-1263 Director Usual Residence of Decedent death with the Maryland 10a. Stata 10c. City, Town or Location 10b. County than "natural", or flame 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Anne Arundel Severn 1 ☐ Yas 2 ☐ No Director 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1604 Severn Run Court 21144 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, atc. Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiens.
The file of the marked other than "natural", or Neury or other traumals avent, the Media.

Iny or other traumals avent, the Media. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 White 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary Teacher Education altimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Philip Hoffman Venda Fountaine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1604 Severn Run Court, Severn, MD 21144 Ronald A. Warner (Husband) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Department of Important: If any Injury or phose. Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 08/07 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 e, of complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, List brily one cause on each line. Approximata Intarval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. **Physician** /Medical Immediata Cause (Final CArdine Arrhythmia minutes diseasa or condition resulting in death) Examiner Examiner Dertension The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of) USS 28 0 signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown ď 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed? Completed Deen completion of cause of death? After this certificate has 1 Yas 2 No 1 Yas 2 No Be 25. Was casa referred to medical axaminer? 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 A Rasidance 6 Other (Specify) Certification: To 1 XYes 2 No 28a. Date of Injury (Month, Day Year) funaral 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred spital or Attending Piours after death.
neral Director: After ti 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital Medical 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier Deputy 06054 elle e and address of person who complete of death (Item 23a) (Type, Print) 695 America 21035 MAM Nes un D 31. Dala filed (Month, Day, Year) 32 Registrar's Signature State AUG 10 ooks Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death Amend Item #5,G775,per FH,gap,9/3/00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1999 5:05 P.M. Richard N. Wolf August 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel General Hosp. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 086 36 0881 8. Date of Birth (Month, Pay. Year) NOV . 14, 1944 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Pennsylvania Days Hours 54 Yrs. Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Wayes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 622 Edwards Road 21401 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 Å Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use, retired): Computer Specialist 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dept of Army Elementary/Secondery (0-12) College (1-4or 5+) Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William C. Wolf Dorothy Buckley 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice L. Wolf 622 Edwards Rd. Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/12/9gBaltimore, MD. Metro Crematory, Inc. 4 Donation 5 Other (Specify) 22. Name and Address of Fecility Stallings Funeral Home 21. Signature of Funeral Service Lie 3111 Mountain road, Pasadena, Md. 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one capital or each line. Approximate Interval Between Onset and Death 844 Immediate Cause (Final disease or condition resulting in death) e to (or as a consequence of) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that inflated events resulting in death) Last Due to (or as e consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Wes an autopsy performed? NON 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at

Physician /Medical Examiner

Examiner

Physician/Medical

by

Completed

Be

Certification: To

edical

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signature a

4 III Homicide

Physician

/Medical

Examiner

Directo

Funeral

A

Completed

Be

Funeral

Director

tem 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Heelth and Mentel hyglent Important: if item 27 is marked other tha any Injury or other traumatic event, the page.

Baltimore, Maryland 21215-0020

with the Meryland

sician and burial-trensit the attending physician hed for use as the buna Box 68760 P.O. Division of Vital Records. certificate has

this To the Heapital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral

State Registrar

31. Date filed (Month, Day, AUG 1 0

5 Pending Investigation

6 ☐ Could not be

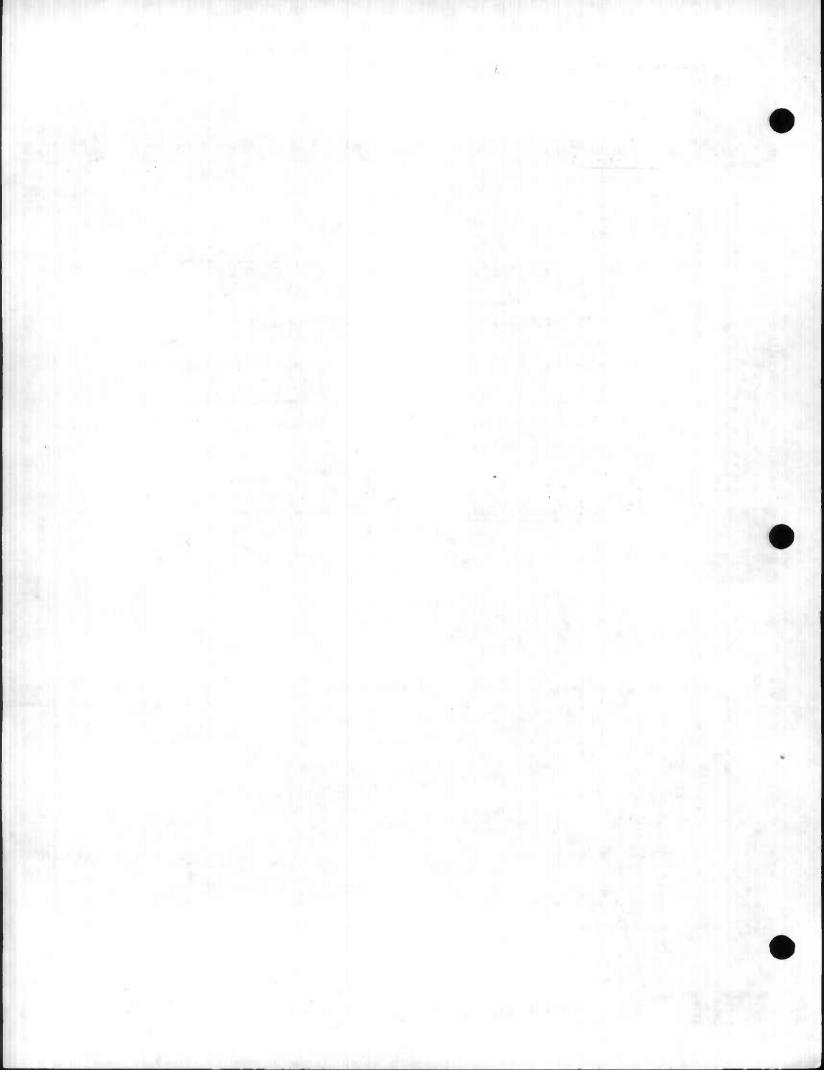
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

In the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year) 6

28f. Location (Street and Number or Rural Route Number, City or Town, State)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST Elsie Elizabeth Young 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De St. Agnes Hospital Baltimore N/A | Wind | Win. | B. Date of Birth (Month, Day, Year) | Aug • 25, 1915 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days 1□M 2X F Months 725 09 8742 83 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3300 Benson Avenue 21227 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: White 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regina Lederor Henry Modtart 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Ingle 108 E. Church Street Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 N Buriel 2 ☐ Cremation 3 ☐ Removel from State 8/11/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. Gerome manuouske 4001 Ritchie Highway Baltimore, Md. 21225 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. leading Pethic v/cen Immediate Cause (Finel Week diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Conpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Box 68760, signed t certificate of Vital or Attending Physician: funeral director this After after death.

Young

AME

Physician/Medical þ Completed Be

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Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumedic event

Physician

/Medical

Examiner

21215-0020

altimore, Maryland

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Be

29a, Certifier

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Netural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MO

29c. License number D46704 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMPHONDE

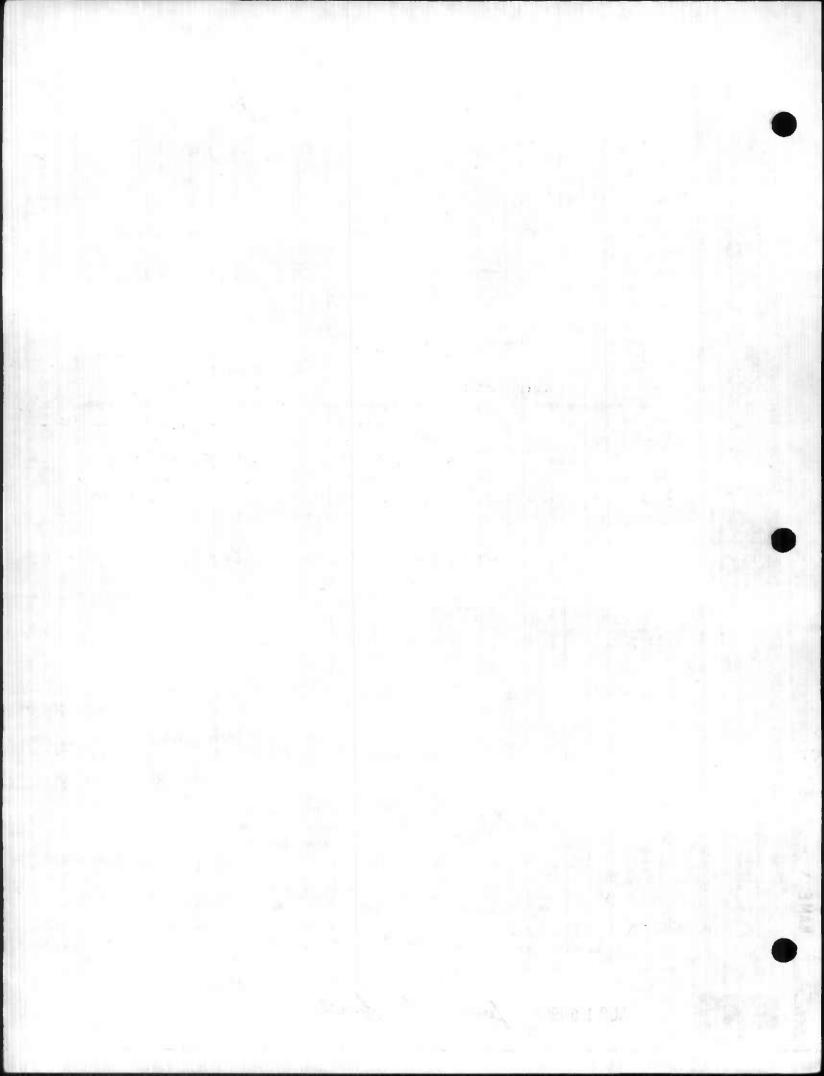
MUTOMBO 31. Date filed (Month, Day, Year)

32. Registrar's Signature AUG 1 0 1999

ST AGNES HOSPITAL

State Registrar

To the Hospital within 24 hours a To the Funeral D



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey Year Month **Physician** Young Catharine 5 8:00 pm August 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FutureCare - Chesapeake Arnold Anne Arundel f Under 1 Yeer If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 414-66-9956 1 ☐ M 2 💢 F 94 Yrs. Director July 17, 1905 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes RNO Anne Arundel Director Crownsville 25a or 28a-t 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 1181 Harbor Oak Drive 21032 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. pamili. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Ilem 27 is marked other than "natural", or its 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give 1 Yes 2 No White altimore, Maryland 21215-0020 Specify: à 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Nursing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 Frank S. Kreitzer Mary Marshall 19e. Informent'a Neme/Retetionship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Kreitzer (Nephew) 1181 Harbor Oak Drive, Crownsville, MD 21032 20b. Ptece of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Dete etery, crematory or other place) 6 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State Zion Lutheran Reformed Cem. Womelsdorf, PA 4 ☐ Donation 5 ☐ Other (Specify) 08/18 21. Signeture of Fundin Service Licensee 22. Neme end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Causa (Finet diseese or condition resulting In deeth) /Medical ARTERIOSCIENOTIC CARDIOVAS ENVAN Examiner Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last Due to (or as a consequence ot) physician the Due to (or es e consequence of): USA AS Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? cate has been signed by to page 2 should be detach 3 Probably 4 2 Unknown 1 ☐ Yes 2 ☐ No PNGUMONI A þ 24b. Were eutopsy tindings available prior to completion of ceuse of death? Be Completed 24e. Wes an autopay performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To

Box 68760 P.O. Records, Division of Vital

certificate or Attanding Physician: director this funeral After death. To the Hospital or Atlandif within 24 hours after death.
To the Funeral Director: A completely filled in by the fi

State Registrar

Alluse

5 Panding

Investigation

6 Could not be determined

28b. Time of

28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify)

29c. License number D 21776

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner es atated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Dete signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

AUGUST 6

28d. Describe how injury occurred

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

28a. Dete of Injury (Month, Day Year)

S. HANOVER ST BACTIMORE MUNDRA m 300/

31. Dete filed (Month, Day, Year) AUG 1 0 1999

27. Menner of Death

1 Neturel

2 Accident

3 Suicide

29a. Certifier

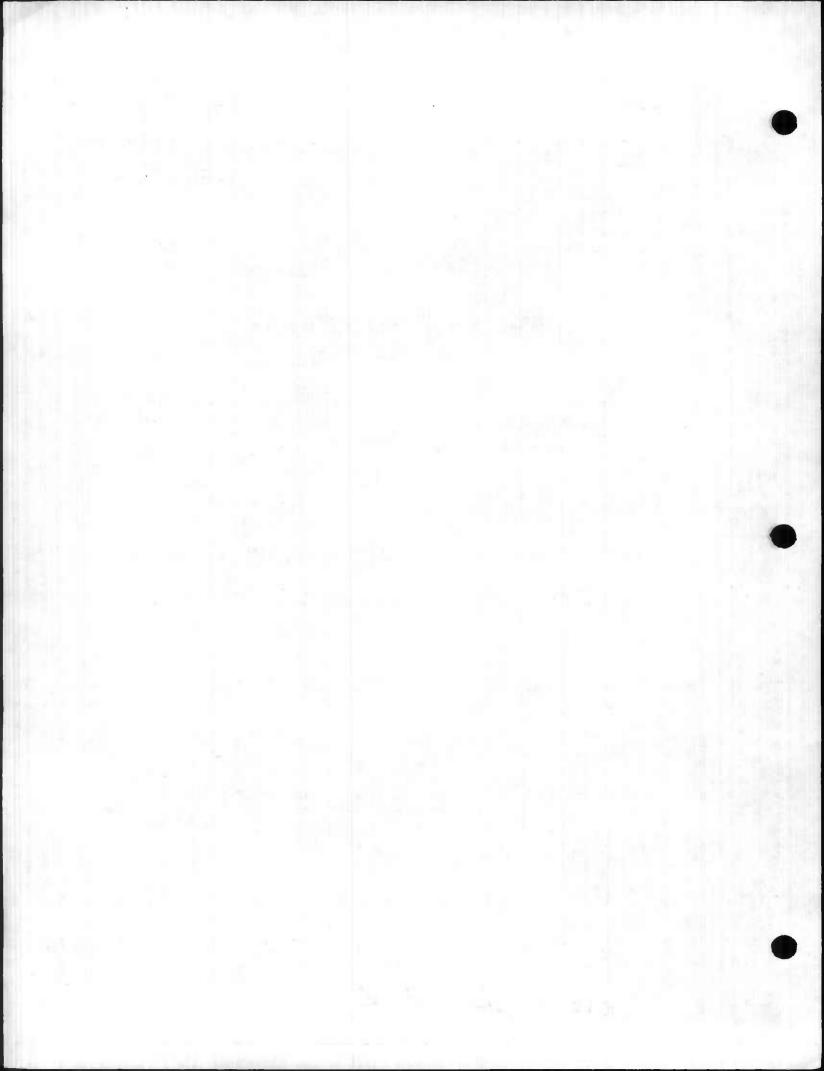
Medical

4 Homicide

(Check only one)

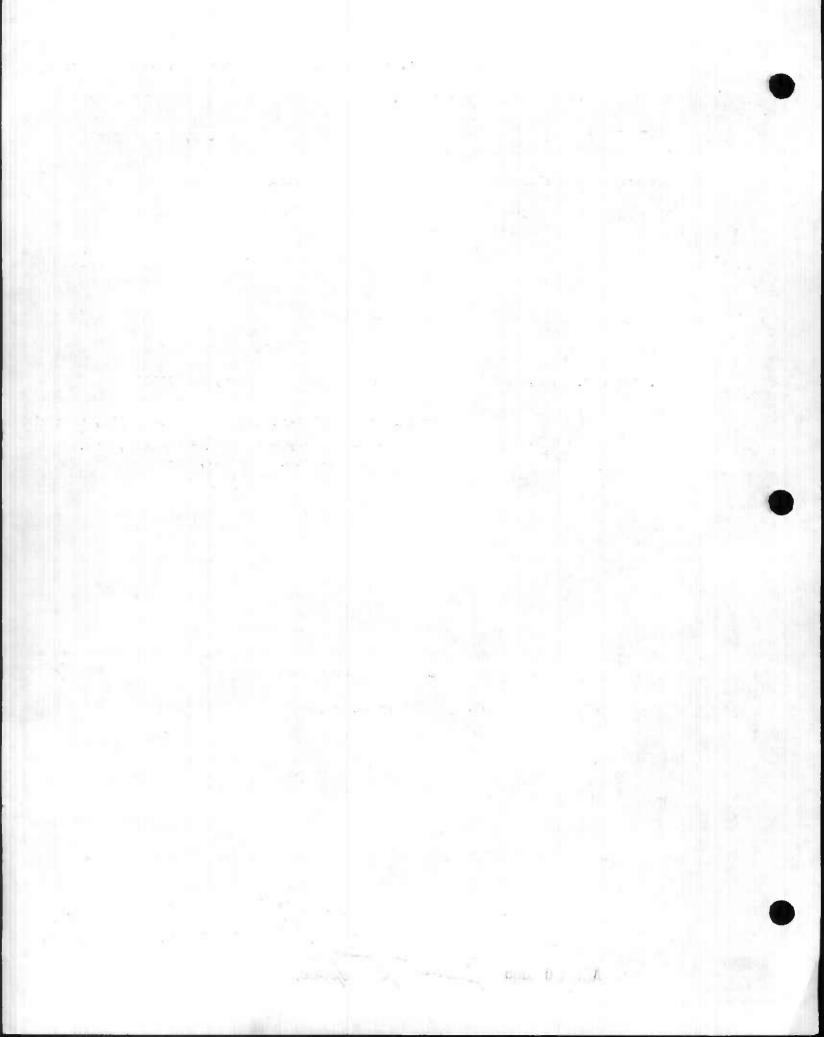
29b. Signature and title of certifier





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle, L.	actl	(Certificate of	Death	2. Date of Dea	Reg. No.	6.3	3. Time of Death
Physician	1. Occoon a Nome (1 11st, Miloure, L	Bessie	В . В	. Zysk	i	Month August	_Day	Year	4:20 PM
/Medical Examiner	4a Facility Neme (If not institution, ga	ve street and number)			4b. City, Town, or Lo		4c. County o		4.20 111
	Genesis Eldercar	e Multi Med	dical Ct	r.	Towson	1	Bal	timo	re
Funeral Director	215-12-8623	Sex 7. Age 1□ M 2€□ F 76	(In yrs. last birth	day) If Under 1 Yeer Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan, 3		9. Birthpla Countr Ita	ce (Stete or Foreign y) 1 V
pur M	Usual Residenca of Decedent 10a. Stete 10b. County		10c. City, Town	or Location		A) 26-1		10	d. Inside City Limits
the Maryland 28a-f show notified at rector	Maryland B	altimore			Eastwood				1 ☐ Yes 2∕☐ No
or 28e-fa be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh		
ath w	7277 Bridgewood				21224		United		
5-0020 72 hours after death with the Marylan natural; or lisens 23e or 28e-1 show tigal Examilies; must be notified, at steed by Furneral Director	11. Marital Sfetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Wes Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 Tho	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yea or No- Rican, etc.)		White, e	
72 houn ratural, scal Ex	15. Decedent's E	ducation	16a. [Decedent's Usuel Occup	pation		16b. Kind of Bus		
1 21215-0 ed within 72 ho yrgiene. wer than "natum 4, the Medical.	(Specify only highest gi Elementery/Secondery (0-12)	College (1-4or 5	+)	Give kind of work done life. DO NOT use retire	during most or work d)	ing			
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Viand vidite file wented the rite even To Be	Dante Barbini	1)				a Ferran			
of the same	19a. Informent's Neme/Relationship	(Type, Print)	19b.	Meiling Address (Street				tate, Zip (Code)
	Mr. Dante P. Zy	ski/Son		89 Ruel Ave	nue Hanc	ver, PA	17331		
Baltimore, aemil. Pages 1 ac Department of Hea reportant: if Hem 2 my injury or othe MGB.	20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of		cemetery	Disposition (Neme of cometory or other pleasens of Fait		Dete /9/99	20c. Location - C		m, State Maryland
Balt permit Depart Importu	21. Signature of Funeral Service Lice			Dundalk Marvland		c. 222			
	23a. Pert Enter the disease, or cor shock, or heert feiture. List only	nplications that caused	the deeth. Do no						Approximate interval Between
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)	ceran		Onset end Deeth					
ficate be executed physician and is the buriat-transit edical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence ot):								
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o deat the att thed to ysicia	Part II. Other significant conditions	contributing to death bu	t not resulting in t	the underlying cause give	ren in Pert I.	23b. Did to	obacco usa cont	ributs to	the causs of death?
us, F.C. DOX ires that the death cer signed by the attendin d be detached for use d by Physician/N	CHRENIC	ATRIAL	- Fig	BRILLAT	100).	101	/sa 2□No	B □ Probe	ably 4 Vinknown
aw requests been 2 ahou	CONGESTIVE	ITGA	RT 3	FAILUR	€ .	24a. Was a perfor		avai	e autopsy tindings lable prior fo spletion of cause eath?
The page 100	The same of the sa					1 🗆 Y	es 2200	10	Yes 2□ No
delan: The certificate rector, pag	25. Wes case referred to medical examiner?	Managhali		la.	26. Place of Deat	h (Check only or	ne)		
Physician: rthis certific ral director,	1 ☐ Yes 2 No 27. Menner of Death	Hospital: 1 Inpatier 28a. Date of Injury		patient 3LI DOA			enca 6 Other		
Affer Ition	Natural 5 Pending	(Month, Day	Year) 28b. Tir	ury Wor	k? Yes 2 □ No	200. Describe n	ow injury occurred	J	
Lai or Attending Physical or after death. al Director: After this led in by the funeral of Certification: To	3 Suicide 6 Could not to determined	De Diese of Jain	ry - At home, ferr (Specify)	n, street, fectory, office		28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
To the Hospital or Attending Physical To the Hospital or Attending Physical To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	29a. Certifier (Check only one) Certifying Plant Certify	hysicien: To the best of miner: On the basis of and menner stell	examinetion and/	deeth occurred at the tir or investigation, in my o	ne, dete and place, pinion, deeth occurr	end due to the cred at the time, o	ause(s) and man late end plece, ar	ner as sta d due to (ted. he cause(s)
Within To the comp	29b. Signeture end fitle of certifier	, ,		29c. Licens	e number	- 4	29d. Date signed	(Month, D	ay, Year)
	1000	nel		DS	236	0	811	019	79
	30. Name and address of person who		ath (Item 23a) (T	ype, Print) ICUC	131R .	SARK	CESUIL	13	us.
State Registrar	31. Date filed (Month, Day, Year)	32. Registra	Signeture	B. Spo	els				



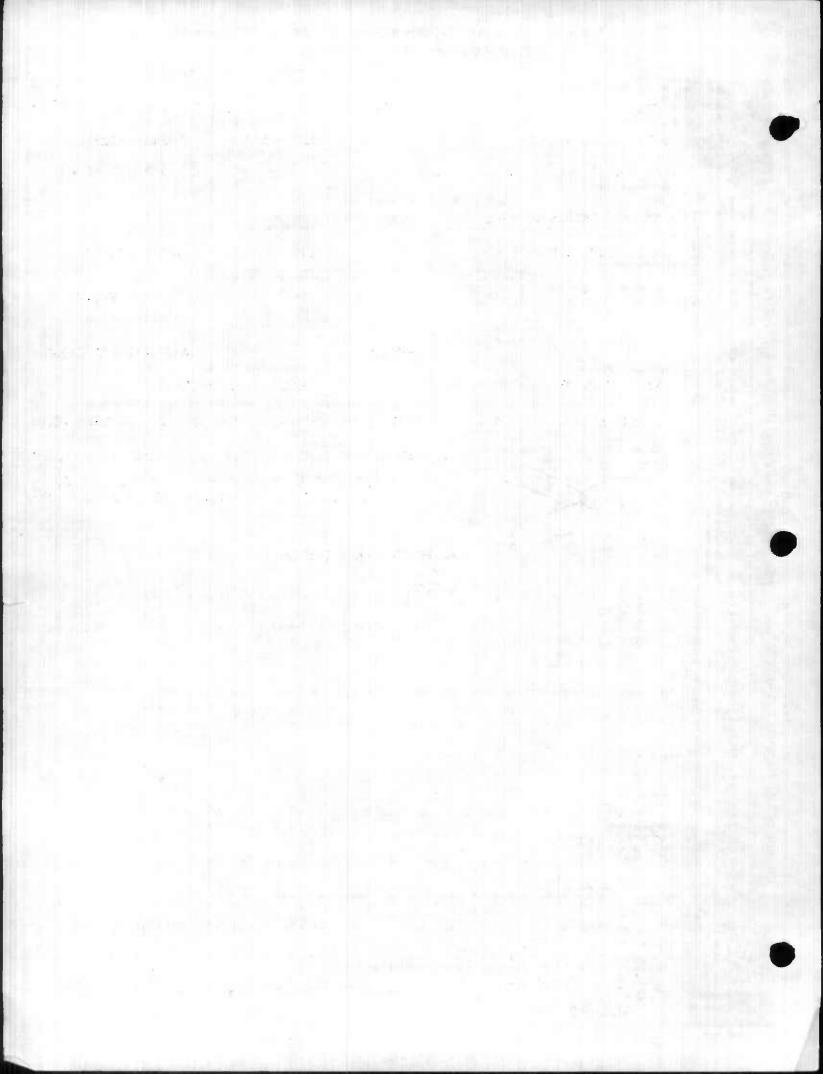
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:05 AM TONA **ABRAMS** 20, 1999 JULY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 8335 12TH. AVENUE SILVER SPRING PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□ M 2₽F Yrs. 577-38-4237 95 DEC. 1903 26, MARYLAND **Director** Usual Residenca of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental hygiene. Interest, or items 23a or 28a-f ehow mit: if them 27 is marked other than 'naturel', or items 23a or 28a-f ehow any or other treumatic event, the Medical Evant are mainten required any or other treumatic event, the Medical Evant are mainten required as 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND Director PRINCE GEORGES SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8335 12TH. AVENUE 20903 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE P 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education ify only highast grada complated) 16b. Kind of Business/Industry (Specify Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY AMERICAN RED CROSS 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be ISRAEL HURWITZ BESSIE YUDELEVITZ 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) P. EARL ABRAMS (SON) 10919 LOMBARDY ROAD-SILVER SPRING, MARYLAND 20901 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State permit. Page Department or Important: if i any injury or once. KING DAVID MEM. GARDEN 7/22/99 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Lisensee. 22 Name 24 Address of Facility BERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 23a. Part1. firmer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate interval Betwe Interval Deling Onset and Death **Physician** /Medical fmmediate Ceuse (Final Congestive diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner Dimentia physician and s the bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, erebrovascular DISCUSE Physician/Medical Due to (or as a consequence of) 80 attending p ertension signed by the a d be deteched f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 1 Yas 20 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? certificate has b irector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) After this funeral 27. Manper of Deeth 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? Certification: 1 Naturai 5 Pending 1 TYes 2 □ No investigation 24 hours efter death. Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Spacify) filled in by 4 Homicide Hospital 29a. Certifier 1 🗹 Cartifying Physicfan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as steted Medical **Sympletely** (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. To the I within 2 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) m 30. Name and address of person who comp cause of death (item 23e) (Type, Print) 1ew hire

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32. Registrar's Signature

State Registrar 31. Date filed (Month.

Day Yaar)



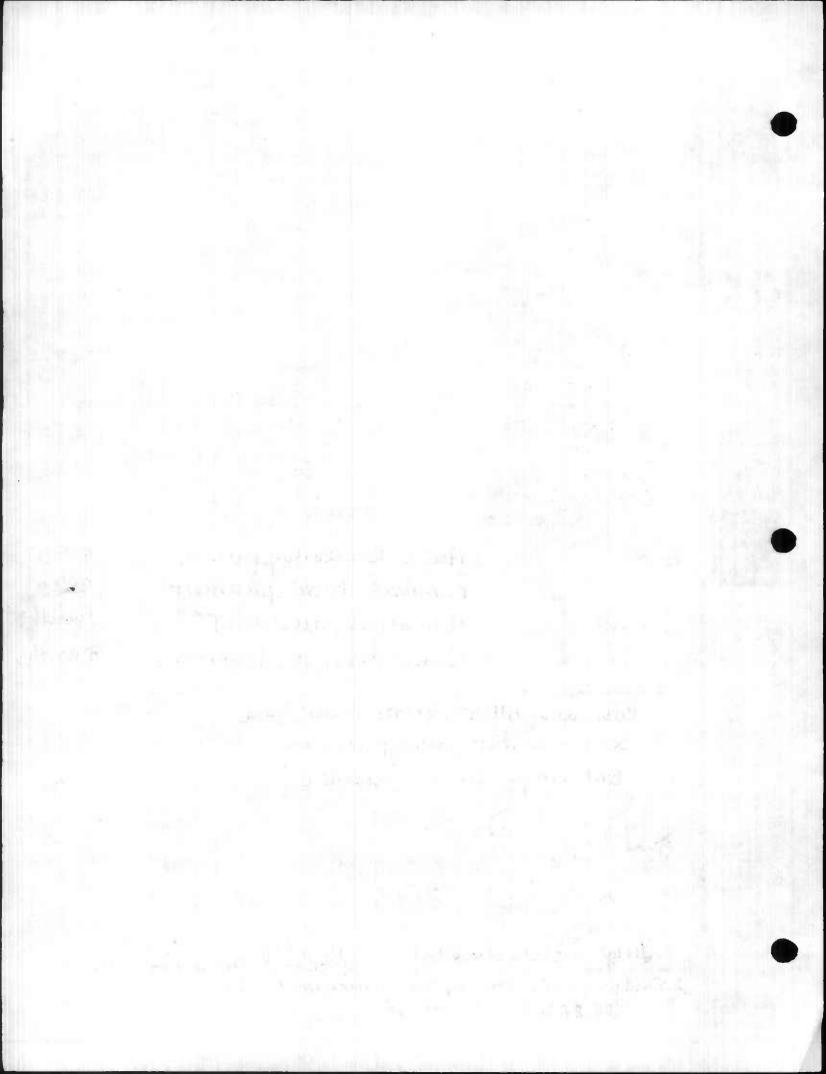
State of Maryland / Department of Health and Mental Hygiene 0

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Physician ava 25, A99 4c. County of Death 4b. City, Town, or Location of Death William J. Arnold /Medical 4a Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel Hunder 24 Hrs. 8. Dete of Birth (Month, Day, Year)

Dec. 15,1919 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 10 M 2□ F Months 090-10-3155 79 Director New York Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Annapolis 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 Mastline Drive 21401 USA 12. Was Decedent Ever in U.S. Amped Forces? 1/2 X/9s 2 □ No If Yes, Give Year or Datas: 1942-45 Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 72 hours after 1 Never Married 2 Married "natural", or Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Fages 1 and 2 should be filed within 72. Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "nat, any injury or other traumatic event, the Marine once. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Printer Federal Government 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 8 Jacob Arnold McGowan (unknown) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Frances B. Arnold/ Wife 1014 Mastline Drive Annapolis, MD 21401 Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata XXBurial 2 Cremation 3 Removal from Stata MD Veterans Cemetery 7-29-99 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 48hu Examine Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 145 BULLOW Box 68760. Physician/Medical Dua to (o as a consequence of): dysfunction Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Attuosclewinc Division of Vital Records, à 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed Deen END SMAC 1 ☐ Yes 2 No 1 Yes 2 No 25. Was casa referred to medical axaminer? 26. Placa of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 20 No 0 this funeral To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 7125199 108314 ounauces mi georgo C. Somarcos mo. 30. Name and address of p of person who completed cause of death (ttem 23a) (Type, Print) Awwapolis, maryland
32. Registrar's Signature 21401 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Evelyn G. Brown July 19, 1999 6:25 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town. or Location of Death 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF 79 Yrs. 578-52-3618 Director April 23, 1920 Washington, DC Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at Washington, D.C. Director 1 Tyes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2125 First Street, N.W. 20001 United States death Funeral 14. Race - American Indian, Bleck, White, etc. AITICAN 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Face 1 and 2 should be filed within 72 hours after men of Health and Mental Hyglene.
If I Rem 27 Is marked other than "natural", or Ne mer or other traumatic event, pre Medical Engine 1 Navar Marriad 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: à _{Specily:} American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Institute Elementery/Secondery (0-12) College (1-4or 5+) of Health Unit Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Glover Annie Grant 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jesse L. Brown, Jr. / Son 2125 First Street, N.W., Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burlal 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation # Other (Specify) Triangle, VA Quantico National 17/26/99 21. Signature of Funeral Service Licensee Name and Address of Facilit McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Pagt. Enset the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical · PNEUMONIA OUR MONTH Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. Yes 2 No 3 Probably 4 Unknown LARYDGAL CANCER MULTIPOCAL ATRIAL TACKY CARDIA. Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? SEPTICEMIA completion of cause of death? 1 Yes 25€No 1 Yes 2 No Division of Vital 89 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 25€No riginpatient 2□ ER/Outpatient 3□ DOA 를 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Affar 1 Natural 2 Accident 5 Pending or Attending 1 Yes 2 No investigation after death Director: 3 Suicide 5 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide a Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Within 24 ho To the Fune completely I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C Strengel D D08944 30. Name and address of person who completed use of death (Item 23a) (Type, Print) 3720 FARRAGUT NIE MARTIN C. SHARGEL

DHMH 16 Rev 6/95

State

Registrar

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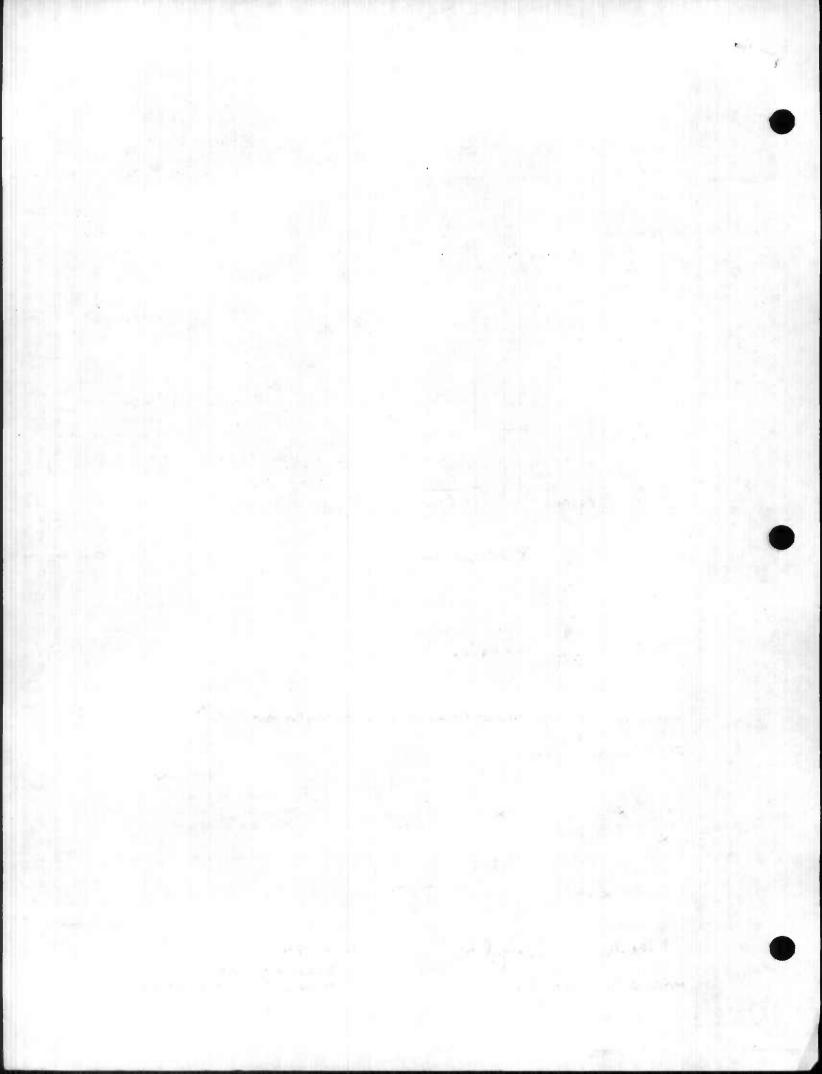
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32. Registrer's Signature

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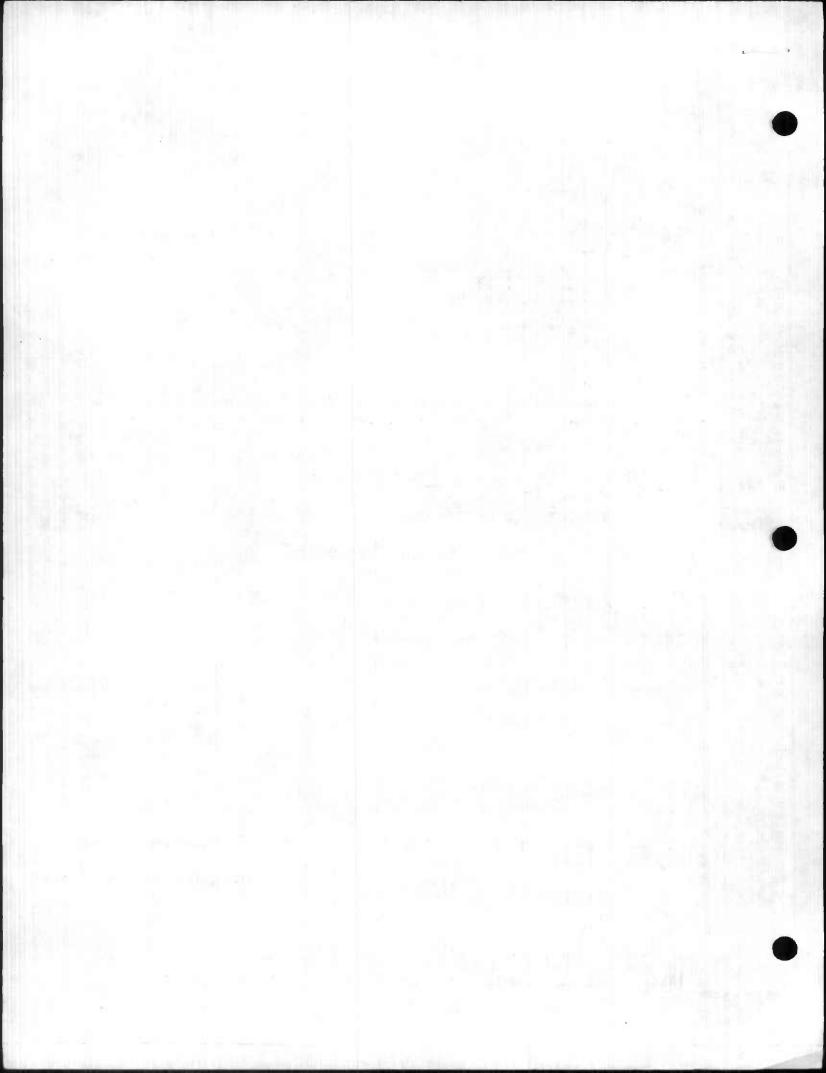
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State of Maryland / Department of Health and Mental Hygiene

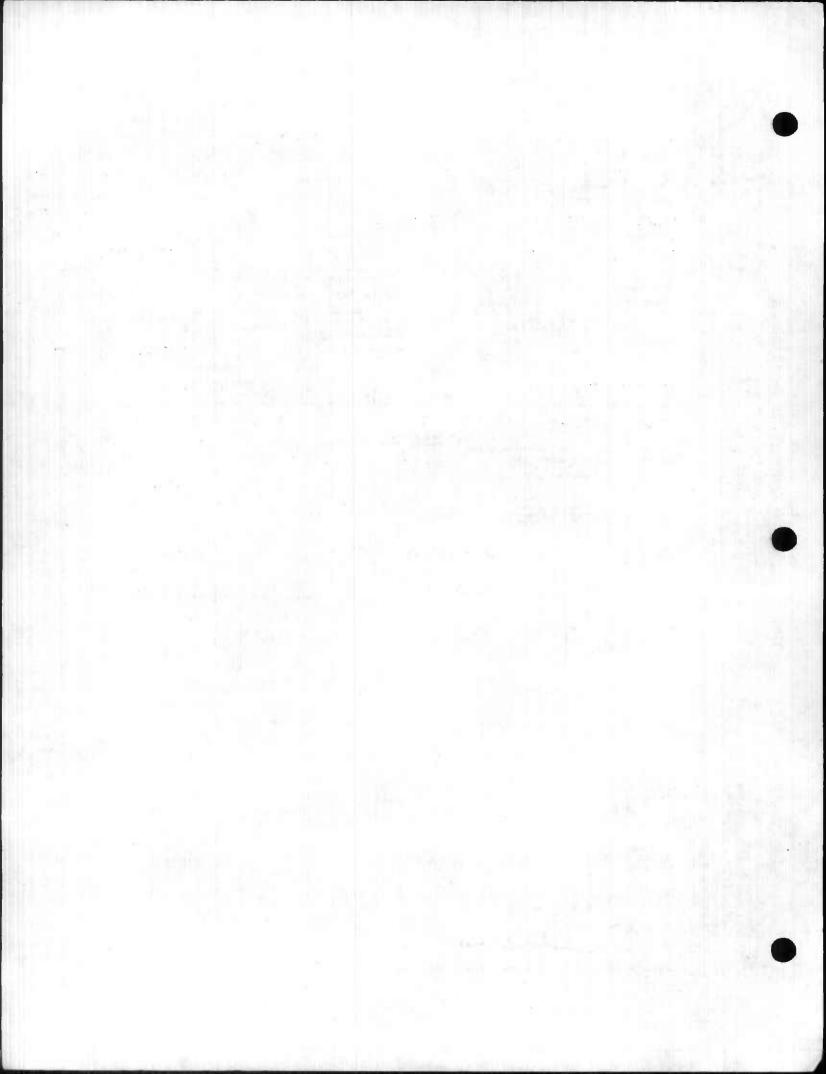
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2 should and Mer is marks sumatic		9a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street	and Numbe	er or Run	al Route Numb	er, City or 1	Town, State, Zi	ip Code)
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omit. Pages 1 and Separtment of Health moortant: If New 27 my Injury or other these	2	Oa. Method of Disposition			Place of Dispo	sition (Name	of or niar	ne)		Date	20c. Loca	ition - City or T	own, State
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth **Physician** Jesse **Blakely** July 1999 6:00 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner Washington Adventist Hospital Takoma Park If Under 24 Hrs. 8. De Montgomery If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 10 M 2□ F Months Deys Hours Min. Yrs 241-14-5907 Feb. 16, 1921 North Carolina Usuel Residence of Deceden 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland | Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? #202 8109 Tahona Drive 20903 Funeral USA 14. Reca - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Tyes 2 No If Yes, Give Yeer or Detes: WWII 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: à 3 Widowed 4 Divorced **Black** Completed 16a. Dacedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Bethesda Country Elementery/Secondery (0-12) College (1-4or 5+) Locker Room Manager 17. Fathar's Nema (First, Middle, Lest) 18. Mother's Name (First, Middla, Maiden Surneme) Jessie Blakely Unknown 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 8109 Tahona Drive #202 Silver Spring, Maryland ce of Disposition (Name of Dete 20c. Location - City or Town, State Julia Blakely (wife) 20903 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 7/26/99 Silver Spring, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. les Stile 500 University Blvd., W., Silver Spring, MD 20901 23a. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immedieta Ceusa (Finel diseese or condition resulting in death) Due to (or as a consaquanca of): Examiner dugney eus Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): 1(Cas Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings evailable prior to completion of cause of deeth? 24e. Was an autopsy Completed 1 Yes 2 PNO 1 □ Yes 2 □ No 26. Place of Deeth (Check only ona) 25. Wes care valuered to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 10 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledga, daath occurred et tha tima, data and pleca, and due to tha causa(s) and manner es stated. Medical 2 Madfcaf Exampher: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end dua to the causa(s) end manner stated. 29b. Signetyre end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) upround 726265

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pernit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylen Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examena must be notified as

Physician /Medical

Examiner

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page 2

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or Attending Physician:

Division of Vital Records, P.O. Box 68760,

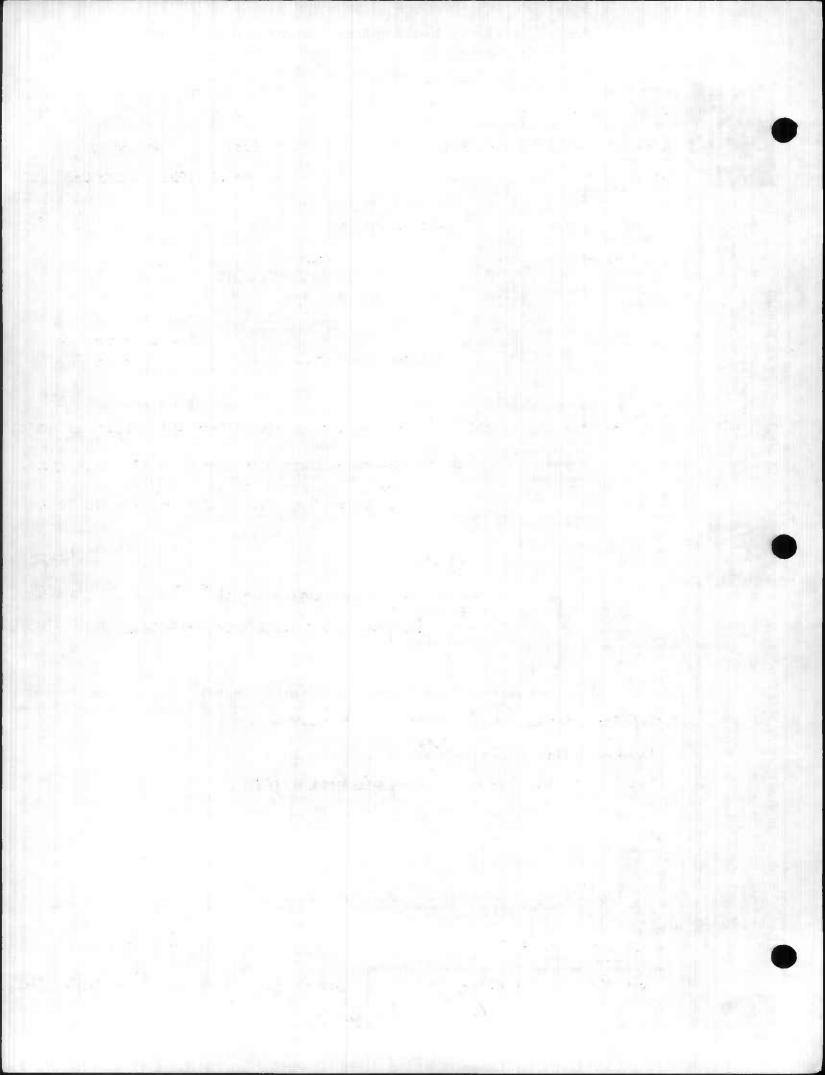
Baltimore, Maryland 21215-0020

State Registrar

aima 31. Dete filed (Month, Day, Yeer) H/argu4Z 32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year 23, 1999 4:40pm Jacqueline Elizabeth Blanco July | 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) Days 1□M 2\ F Hours Months 219-33-3568 Oct. 13, 1964 Nicaragua Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2XX No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 867 Clopper Road #T-4 20878 Nicaragua Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American indian, Bleck, White, etc. 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Never Merried 2 Merried 1 ☐ Yes 2 🛣 No Specify: Nicaraguan Specify: Hispanic 1 Ves 2 No If Yes, Give Yeer or Detes: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Bavardo Salguera Anna Rodriguez 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Samuel L. Blanco, 867 Clopper Road, #T-4 Gaithersburg, MD 20878 husband 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition July 28 20c. Location - City or Town, State 1 X Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 1999 Olney, Maryland 21. Signeture of Funerel Service Licensee 22 Name and Address of Facility DeVol Funeral Home 20877 10 E. Deer Park Dr., Gaithersburg, MD Us 23a. Pert1. Enter the disease, or complications that crued the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on with line. Approximete Interval Between Onset and Death METMTATIC Immediate Cause (Final disease or condition resulting in death) CERVILIAN CARCINOMA Due to (or as e consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 2000 26. Place of Death (Check only one) Hospitel: Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpetient 3 DOA

Physician /Medical Examiner

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Division of Vital Records,

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at

nit. Pages 1 and 2 should be filed within 72 hours after of arment of Health and Mental hygiene. ortant: If Idem 27 is marked other than "netural", or iter injury or other traumatic event, me Medical Examine

Baltimore, Maryland 21215-0020

with the Maryland

death

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest

25. Was case referred to medical examiner? 1 ☐ Yes No 27. Menner of Death 5 Pending

investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

28e. Dete of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 Yes 2 No

DN

28d. Describe how injury occurred

Cortifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner steted.

OLNET!

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signature and

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Prince 18111 JOSEPH 1440

1999 2 6 31. Date filed /Month

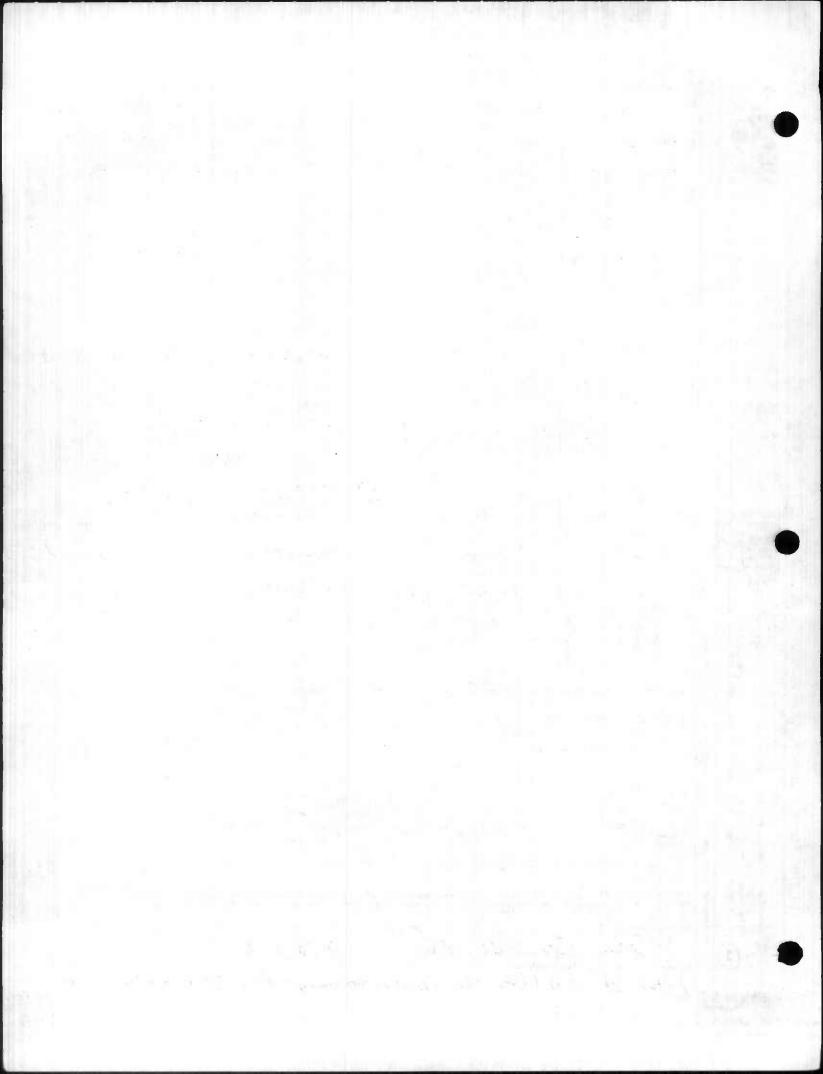
32 Registrer's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	/Medi		EOITH 4a. Fecility Neme (If not institution, giva	BOND			th Ch. Town as	July	1	-	6:30pm
	Exami	ner					4b. City, Town, or I Hyattsvi			of Death	orge
-	-		Heartland of Hyat 5. Social Security Number 6. Se		n yrs. lest birthday)	If Under 1 Yaar	-				
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020	d within 72 hours after death with the Maryland plens. Jens. Than "natural", or items 23s or 28s-1 show the Modeal Exercises must be in itted	by Funeral Director	1 Never Married 2 Married 3 Widowad 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		If Yes, specify Cub	dispenic Origin? (Sen, Mexican, Puert Specify:	o Rican, etc.)	Specify	a - America k, White, a	
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Jar	2 2 2		19e. Informent's Neme/Reletionship (T)	, ,	19b. Meilir	ng Address (Street	end Number or Ru	ral Route Numbe	r, City or Town,	Stete, Zip	Code)
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Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 any Injury or other tonce.		20e. Method of Disposition 126 Buriel 2 Cremetion 3 F 4 Donetion 5 Other (Specify)			natory or other ple	ce) emetery	7/29/99	20c. Location - Clint		
Balt	Depart Import any inj once.		21. Signeture of Funeral Servica Licens	96	Mortici et, N.W.	ans, In	C. 0011				
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	nding physician and usa as the burial-transit	Medical Examiner	Ceuse (Disease or Injury that initiated events resulting In deeth) Lest Ceuse (Disease or Injury that initiated events resulting In deeth) Lest						dar Dis	eso	
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or Vita	9 0	10	exeminer? 1 Yes 2 No	lospitel:	2 ER/Outpetien	t 3 DOA Oth	er: 4 Nursing H	ome 5 Rasid	ence 6 Othe	r (Specify))
VISION O	death. ctor: Aftar th y tha funarel		27. Menner of Deeth 1 ☑ Maturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Dey Yea	28b. Time of Injury	Wor			ow injury occurre		
5 3	Mar d Nrect in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	pecify)			28f. Location (S City or Tow	n, Stete)		
To the Manifest	within 24 hours after to the Funeral Directory (completely filled in	edicai	29e. Certifiar (Check only one)	ician: To the best of my er: On the basis of exa- end mannar steted.	knowledge, deeth minetion end/or Inv	occurred at the tir restigation, in my o	ne, dete end piece, pinion, deeth occur	end due to the c red et the time, o	ause(s) and mai lete end place, a	nner as sta nd due to t	ted. the ceuse(s)
T.	Total	Σ	29b. Signeture end title of certifier		0	29c. Licans	e number	2	9d. Dete signed	(Month, D	ay, Year)
	50		Manell	news	eh	00	185	2	July 28,	199	G
	2 (2)		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, F	Print)	ung Rd	History	sille W	12	5781
	Sta		31. Dete filed (Month, Dey, Year)	32. Degistrer's S		10000	1	17145	जापूर गर		



1. Decedent's Name (First, Middle, Last)

3. Time of Death

2. Date of Death

Charles

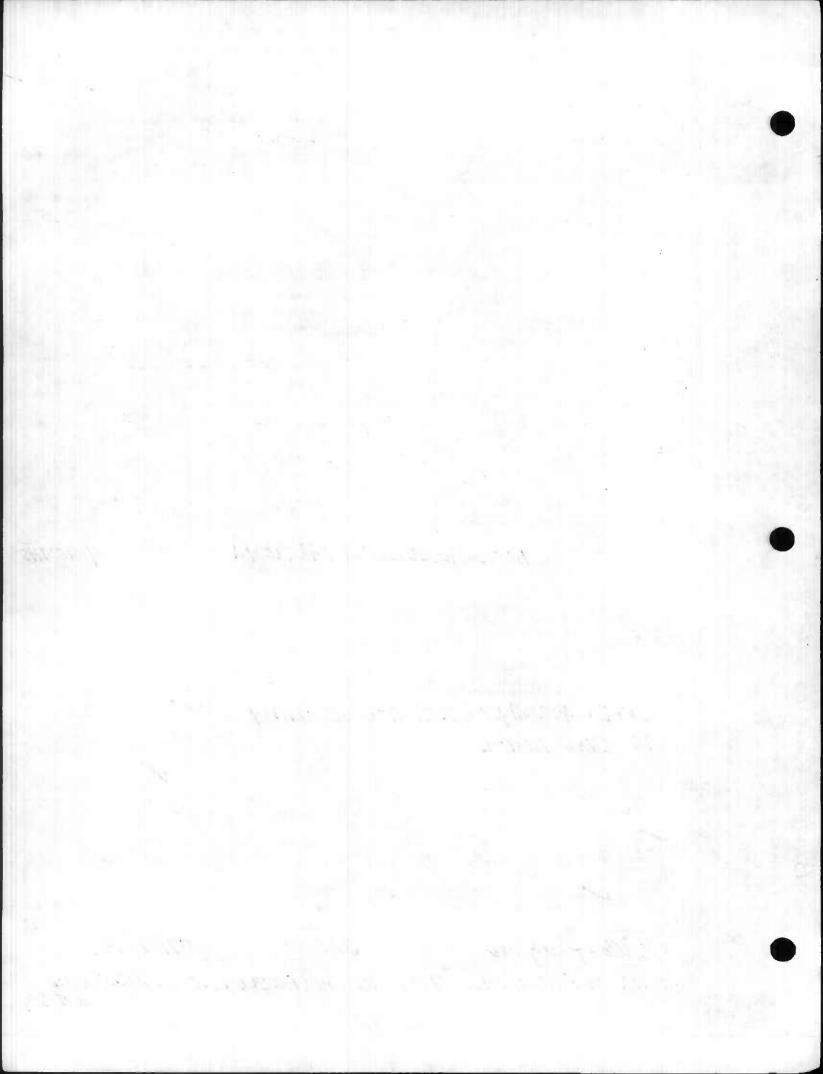
Bowser,

Day 1999 Year July **Physician** 27, 9:43 pm Charles Mark Bowser /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Year)
Apr. 25, 1955 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 15M 20 F 213-66-3932 44 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits mast be notified at 1 ☐ Yes 2 ☑ No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? i 20906 USA 2701 Village Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Herna. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 11. Merital Status 72 hours after 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates: 21215-0020 Specify: White natural, or 1 Yes 2€ No Specify: PY 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ifiled within 7 I Hygiene. Elementery/Secondary (0-12) 12 College (1-4or 5+) Self Employed Plumber Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental 8 Jane Richards Calvin Bowser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) or other tra 2701 Village Lane, Silver Spring, MD 20906 Jennifer M. Bowser/ Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition July 20c. Location - City or Town, State 1 XBuriel 2 Cremetion 3 Removel from Stete Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 1999 Silver Spring, MD 22. Name end Address of Facility 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home, Inc. 500 University Blvd. W., Silver Spring, MD 20901 500 University Blvd. W., Si.

Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,
to hear failure, that only one cause on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting In death) . NON-SMALL CELL LUNG CARGINOMA /Medical MONTHS Examiner Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown UPPER AIRWAY OBSTRUCTION SECONDARY þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed LUNG TUMOR 2 1 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Netural 5 Pending investigation death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital
within 24 hours a
To the Funeral C edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

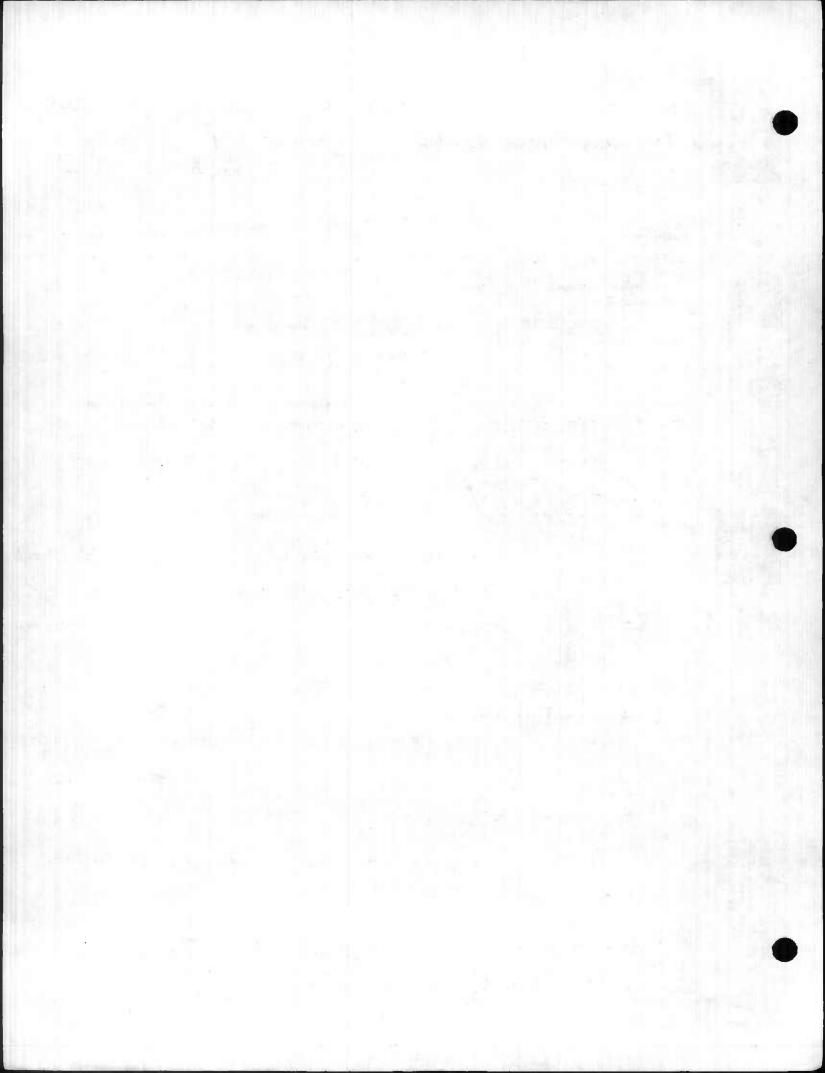
| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. PRIEGO, 9707 MEDICAL CENTER DA. #300 ROCKVILEMO MICTOR MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 29 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 9 5 0 8 6

cian	Decedent's Nemo	e (First, Middle, L	ast)		Certii			2. Dete of D	Reg. No.	3. Time of Deat
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	a. Stete	10b. County		10c. City, To	Wn or Locati	ion				10d. Inside City Lin
Ma 10e	ryland	Montgom	ery	Montg	omery	Villa	ge			1 □ Yes 2 🕅
100	. Street and Num	mber				10f. Zip Code			10g. Citizen of W	het Country?
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5	1 Never Merri	ied 2 Merried	Armed Forces? 1 ☐ Yes 2 💢 !	No			ban, Mexican, Pu	erto Rican, etc.)	Black	, Whita, etc.
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** 22, Helen Marie Brill July. 1999 11:10am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) **Funeral** Days Months 1□M 2⊠F Yrs. 215-26-1392 69 **Director** Nov. 19, 1929 Maryland Usual Rasidence of Decedant permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Heelth and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, he Medical Examiner must be notified at ence. 10a. Stata 10b. County 10c. City. Town or Location t0d. Insida City Limits 1 ☐ Yas 2 ☑ No Directo Marvland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? 20876 19061 Staleybridge Road United States Funeral 14. Race - Amarican indian, Black, Whita, etc. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Datas: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yas 28XNo Specify: by 3 Widowed 4 □ Divorced White Completed 16a. Dacadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15 Dacadent's Education (Specify only highast grada complated) Elamantary/Sacondary (0-12) Coilaga (1-4or 5+) 10 Clerk Magazine Company 18. Mothar's Nama (First, Middle, Maidan Surnama) 17. Fether's Nama (First, Middla, Last) Be Allen Geisbert Lena Lenhart 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Sally Bolton (Sister) 19061 Staleybridge Road, Germantown, MD 20876 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Other (Specify) 7/24/99 Frederick, Maryland Mt. Olivet Cemetery 22, Name end Addrass of Facility DeVol Funeral Home 21. Signeture of Funeral Service Licensee 10 East Deer Park Drive 10 14 Gaithersburg, MD 20877 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete fntarval Batween Onsat and Death **Physician** ASYSTO Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Due to (or as a consaquanca of): a Tracic MUSSIVC Examiner Henry physician and the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last Due to (or as a consequence of): JUTENSION P.O. Box 68760, Physician/Medicai Dua to (or as a consaquanca of): Scherosis 210 Cull 180 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? DAIMMY TUME 1 Yes 2 No 3 Probably 4 Unknown LECT OM Division of Vital Records, ģ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed Stan Clive completion of cause of death? hes certificate he irector, page 20 No 1 Yas 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) Inpatiant 2 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannag of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: Natural 5 Panding invastigation 1 Yas 2 No deeth. 2 Accident after deetl Director: 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian edicai To the Hosp within 24 ho To the Fune completely fi (Check only one)

29c. Licansa number

Sports

the completed cause of death (Item 23a) (Type, Printly) ver 5 (1 >

32. Registrar's Signatura

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29d. Data signad (Month, Day, Year)

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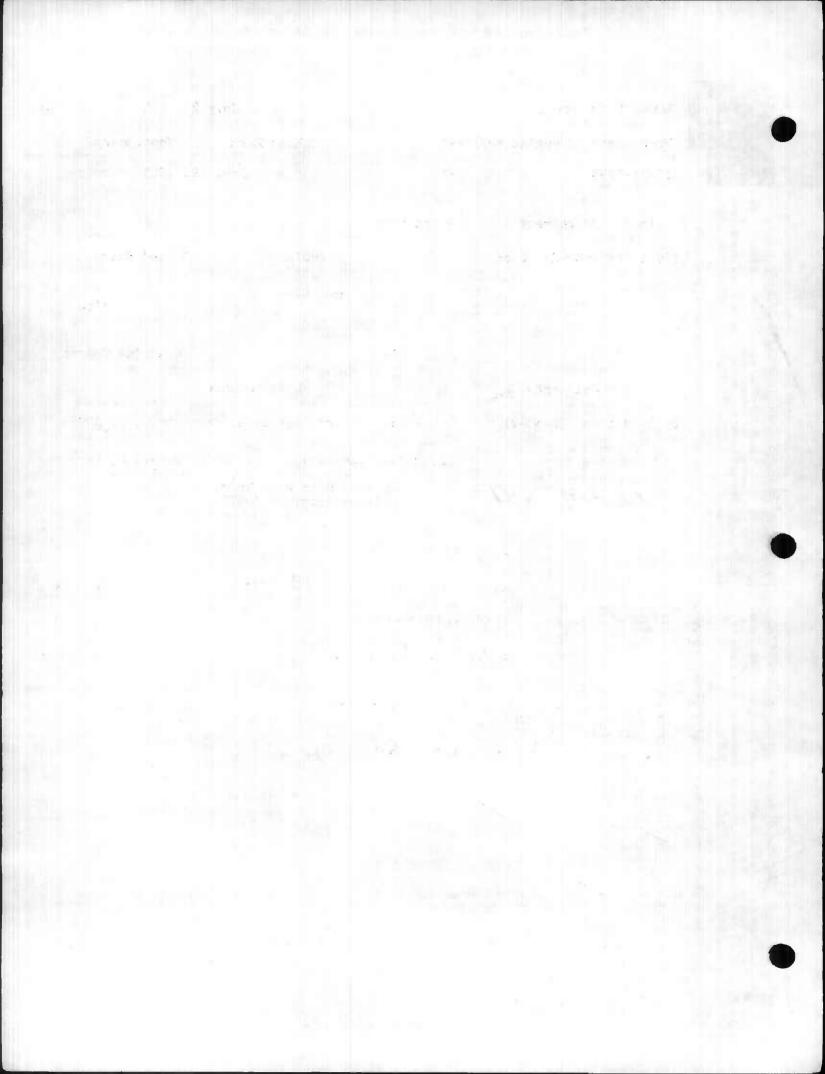
State Registrar 29b. Signeture end title of certifiar

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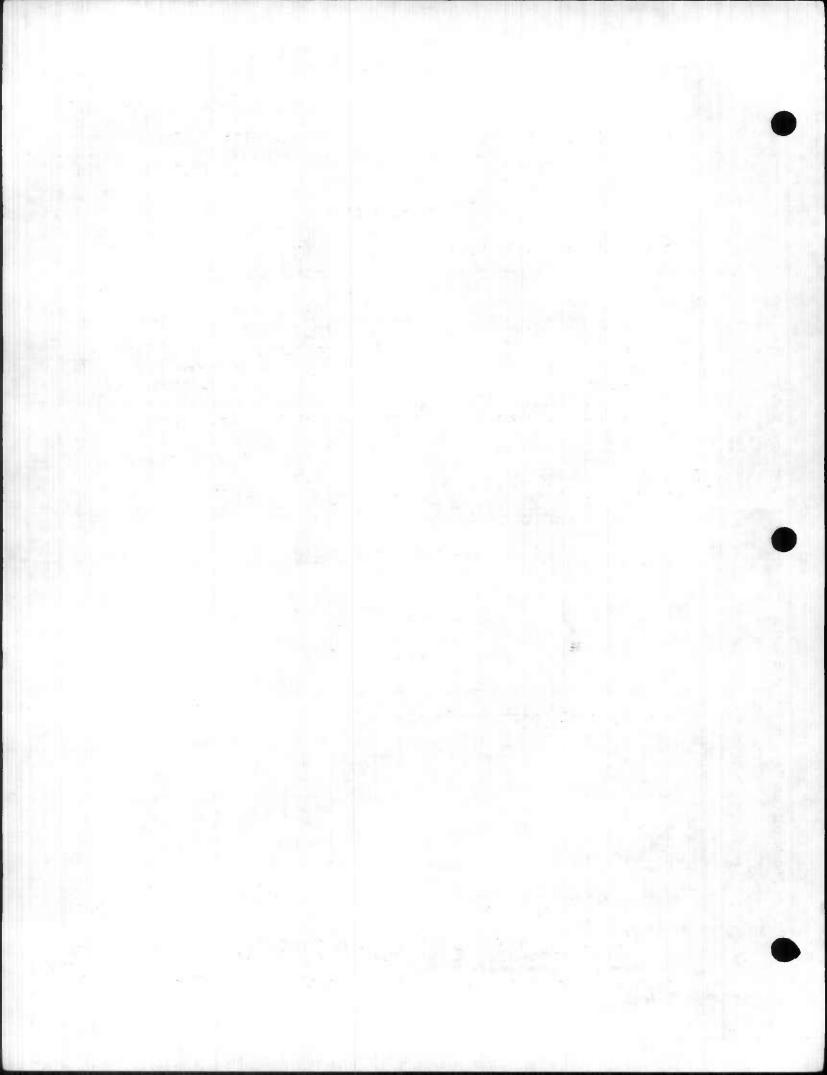
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2 6 1999



State of Maryland / Department of Health and Mental Hygiene 99 25088

			Cer	tificate of	Death	Re	g. No.		
	1. Decedent's Name (First, Middle, i	ast)				2. Date of Death Month			3. Time of Death
Physician (Medical	JAMES	E. BROWNE	Sr.			July		999 4	4:30 PM
/Medical Examiner	4a Facility Name (If not institution, g	ive street and number)		T	4b. City, Town, or		4c. County of		
	1005 Chillum	Rd, Apt #4	02		Hyatts	ville	Princ	e Ged	orge
Funeral	Social Security Number 6.		rs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	Voorl	9. Birthplace	e (State or Foreign
Director	579-42-6452 Usual Residence of Decedent	100M 2CF 6	8 Yrs.	MOTHINS Days	Hours Mill	8. Date of Birth (Month, Day, Feb 26	,1931	Wasi	e (State or Foreign h . DC
with the Maryland a or 28a-f show Lbe notified at Director	10s. State 10b. County		City, Town or Loc					10d.	Inside City Limits
Mar Mar	MD Pr.	Geo.	Hyatts	sville					1M Yes 2□No
irra 23e or 28e-f short irrast be notified at neral Director	10e. Street and Number 1005 Chillum	Road, #402		10f. Zip Code	20782	10	g. Citizen of Wh	S . A .	?
na 23	11. Marital Status	12. Was Decedent Ever in				Specify Yes or No-		- American I	Indien.
Examina by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puer Specify:	to Rican, etc.)	Bleck,	White, etc. Blac	
t, the Medical	15. Decedent's (Specify only highest of	Education	16a. Deced	ent's Usuel Occu	pation during most of wo	dring 1	6b. Kind of Bus	iness/Indust	iry
old le	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	OO NOT use retire	ed)				
O BB	12th		Nus	sing As	sistant		N.I.	н.	
18 9	17. Father's Name (First, Middle, La	st)				me (First, Middle, M)	
To E	Unknown					rgaret			
E E	19a. Informant's Name/Relationship	(Type, Print)				ural Route Number,			
27	Joan M. Brown	e (Wife)	1886	52 Bent	Willow	Cir.,	German	town	, MD
or other	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Bernoval from State	-	natory or other pla	Park		Oc. Location - C		
and .	4 Donation 5 Other (Special Service Lice)	7-//		Neme end Addr		1/21/99	Laure	el, M	D
limpo and and	Janga K	Moura	S	NOWDEN OCKVIL	FUNERA	L HOME, 20850	P.A.		
0	23a. Part1. Enter the disease, or co shock, or heart lature. List on	mplications that caused the d				c or respiretory arre	st,	Ap	oproximete tervel Between
Medical aminer	Immediate Cause (Finet disease or condition resulting in death)	Diabet	o (or as a conseq		on			1 1 2	
n and tai-transit Examiner	Sequentially list conditions	U	o (or as a consequ	uence of):				1	
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	Smoker	of Cig	arette	S				
s the bu	that initiated events	C	(or as e consequ						
č . 5	resulting in death) Last		holeste		a				
by the attendir stached for use Physician/									
y sign	Part It. Other significant conditions	contributing to death but not	resulting in the un	derlying cause g	iven in Part I.	/			e cause of death?
	Peripheral	Vascular D	isease			1 🗆 Y o	a 2□No :	3 Probeb	oly 4□Unknown
d by						24a. Wes er	eulopsy	24b. Were	autopsy findings
page 2 should Completed						perform		compl	ble prior to letion of cause
page 2								of dea	
ntificate ptor. pag						1 ☐ Ye	s 2 No	1 🗆 Y	es 2 No
0 2 1	25. Was case referred to medical examiner?	Manadada		10		eth (Check only one)		-4-4
this of the direction o	1 Yes 2 No		□ ER/Outpatien	3LI DON		Home 5 D Reside			
P CO	27. Manger of Death 1 Naturat 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Inje	ork? □Yes 2□No	28d. Describe ho	w injury occurre	d	
To the Funeral Director: After tombietely filled in by the funeral Medical Certification:	3 Suicide 6 Could not determine		t home, lerm, stre ecity)	pet, fectory, office		28f. Location (Str. City or Town		r or Rural R	oute Number,
n 24 houn he Funera pietely fills edical (Physician: To the best of my laminer: On the basis of exam							
Med Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	ise number	29	d. Date signed	(Month. Day	y, Year)
8 4 3	D M	0 01 5		1	20 00	6	7 1	11 0	20
10	PAITH	youl of	mono	U	57 85	8	1-0	1-	17
	,	o completed cause of death (I	COLUMN TO SERVICE		- 1 2 1	Bana ***		h	20895
	Michael J. Fu		10814	Conne	cticut	Ave., Ke	ensing	con,	MD
State	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature 4	han it	,				



State of Maryland / Department of Health and Mental Hygiene 25089 Certificate of Death

		1. Decedent's Name (First, Middle, Las	1)							2. Deta of D	eath		3. Tima of Dec	ath
	Physician (Madical	AMPARO BUENO								July 2	24, ^{Day} 999	Year	10:20) P
	/Medical Examiner	4a Facility Name (If not institution, give	street end number)				1	tb. City, Tow	m, or Lo	cation of Dea	th 4c. Count	y of Death		
T		Springbrook Adve	ntist Nur	sing Hom	ie			Silve	r Sp	oring	Mont	gomer	У	
	Funeral Director	5. Social Security Number 6. Se 228-02-5466	X 7. Age	ge (In yrs. last birthday) If Under 1 Y 88 Yrs. Months Di			ear ays	ar If Under 24 Hrs. 8. Dete of (Month, Aug 1		8. Dete of Bi (Month, D Aug 18			plece (Stete or Fo ntry) ippines	weign
	2 .	Usuet Residence of Decedent 10a, Stata 10b, County	1	10c. City, Town	or Locati	ion							10d. Insida City L	ionite
	f sho md.mt												1 Yas 2 No	
	with the Marylan a or 28a-f show Lbe notified at Director	Maryland Montgo	mery	Silver		10f. Zip Co	de				10g. Citizen of	What Cou	ntry?	
	death with the Maryland ms 23e or 28s-f show traust be notified at herai Director	11330 Classical	Ln	20901				USA						
00		11. Meritel Stetus 1 Never Merried 2 Merried	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give			Decedent es, specify		lispanic Orig an, Mexican, Specify:	in? (Spe Puerto	ecify Yes or N Rican, etc.)	o- 14. Ra Ble Specii	ck, White,	can Indian, etc. Llipino	
00	72 hours after natural, or its deal Examina ated by Fu	3 ₩idowed 4 Divorced	Yaar or Datas:											
Maryland 21215-0020	ed within 72 ho ygiens. er than "natura r, the Medical E Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12)	cation le completed) College (1-4or 5-	+)	Give kind lifa. DO		ccup lone d etired	ation during most i)	of work	ing	16b. Kind of E	catio		
d 2		17. Father's Nama (First, Middle, Last)	0	Professor 18. Mother's Nam					's Name	(First Middle			711	_
lan	id be fill be	Vicente Jimenez									tainab1	,		
ary	and M Marian T	19a. Informant's Neme/Ratationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State,									, State, Zij	Code)		
	afith a 27 le	Ramon J. Bueno/S	Son	113	330 (Class	ica	al Ln,	Si	lver Sp	oring, M	D 209		
ore	1 0 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20e. Method of Disposition 1 Burial 2 Cremetion 3 DF	Dames of from Chate	20b. Ptece of I	of r plac	;e)		Dete	20c. Location	- City or T	own, State			
Ĕ	Pages ment of ant: If its ury or o	4 Donation 5 Other (Specify)		Fort	Linc	coln	Cre	emator	у ! .	Jul 27	Brentw	ood,	MD	
Baltimore,	Departi Departi Importi any in)	4 Donation 5 Other (Specify) Fort Lincoln Crematory Jul 27 Brentwood, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral 11800 New Hampshire Ave, Silver Spri											090	
		23a. Pert1. Enter the disease, or composhock, or heart failure. List only o	lications that caused	the deeth. Do no	ot entar th	na mode o	dyin	g, such as o	ardiac o	or raspiratory	errast,		Approximeta	
5	Physician	shock, or heart failure. List boly o	ge ceuse on aach lin	€.								i	Onset and Deel	th
	/Medical	Immediate Cause (Finet disease or condition		Respi	rato	rv I	ารเ	ıffici	ency	7			1 we	eek
П	Examiner	resulting in deeth)	1	Due to (or es a co								1		
	executed in and tal-transit		b									i		
	eath certificate be executed attending physician and for use as the burial-transit clan/Medical Examir	Sequentially list conditions, if any, leeding to immediate	(Due to (or as a co	nsequen	ice of):								
Box 68760,	slcian buris	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c	Wiston College								1		
68	th certificate be lending physicia r use as the bur an/Medical	resulting in death) Last	L	Due lo (or as a co	nsequen	CB Of):								
XO	th cert fending r use		d			_								
	es that the deatigned by the atterbed for be detached for by Physicia	Part II. Other significant conditions co	ntributing to death bu	t not resulting in t	the under	rlying caus	e giv	en in Pert I.		23b. Did	I tobacco uaa co	ontribute t	o the cause of de	eath?
P.O.	that the dear ed by the att detached for y Physicil	weight loss,	denressi	on, hyne	rter	sion				1□	Yaa 2 No	3 Pro	bably 40 Uni	cnowi
Ś	be d	weight 1035,	depressi	o., .,po	2001		,							
Division of Vital Record	The law requires tate has been sign page 2 should be Completed by	osteoporosis	s, macular	degener	atio	on	_		_		s an autopsy ormed?	av cc	lere eutopsy findity vailabla prior to empletion of caustideath?	
E	Page Con									10	Yes 25 No	1	☐ Yes 2☐ No	
Z z	ysician: The lav is certificate has director, page 2 fo Be Comp	25. Was casa rafarred to medical examinar?	1						of Death	Check only	ona)			
o	Physician: this certific ral director, TO Be (1 Yas 2 No	1	at 2 ER/Outp		3 DOA	Oth	4 DA INUI			idanca 6 Ot		fy)	
E .	After fune	1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		ury	28c.		k? Yes 2□N		280. Describe	how injury occu	1100		
18	or Attending after death. Director: After I in by the fune ertification	3 Suicide 6 Could not be	28a. Piece of Injur	ry - At home, fem						28f. Location	(Street and Num	ber or Run	el Route Number,	
á	tal or Attending P rs after death. al Director: After t ed in by the funera Certification:	4 Homicide	building, etc.							City or To	iwn, State)			
	To the Hoopkal or Attending Physician 24 hours after death to the Funeral Director. After this completally filled in by the funeral Medical Certification: 1		sicien: To the best of ner: On the basis of											
	vithin Fo the comple	29b. Signature and tight of certifier	1	1/		29c. Li	cens	e number			29d. Data sign	ed (Month,	Day, Year)	
	0	· 117	fith	1		D	31	001			July 2	6, 19	999	
	1	30. Name and address of person who co	ompleted cause of the	ath (Item 23a) (T	ype, Prin	nt)								
		Stuart J. Tu	1				y	Center	Dr	, #430	, Greenb	elt,	MD 2077	0

DHMH 16 Rav 6/95

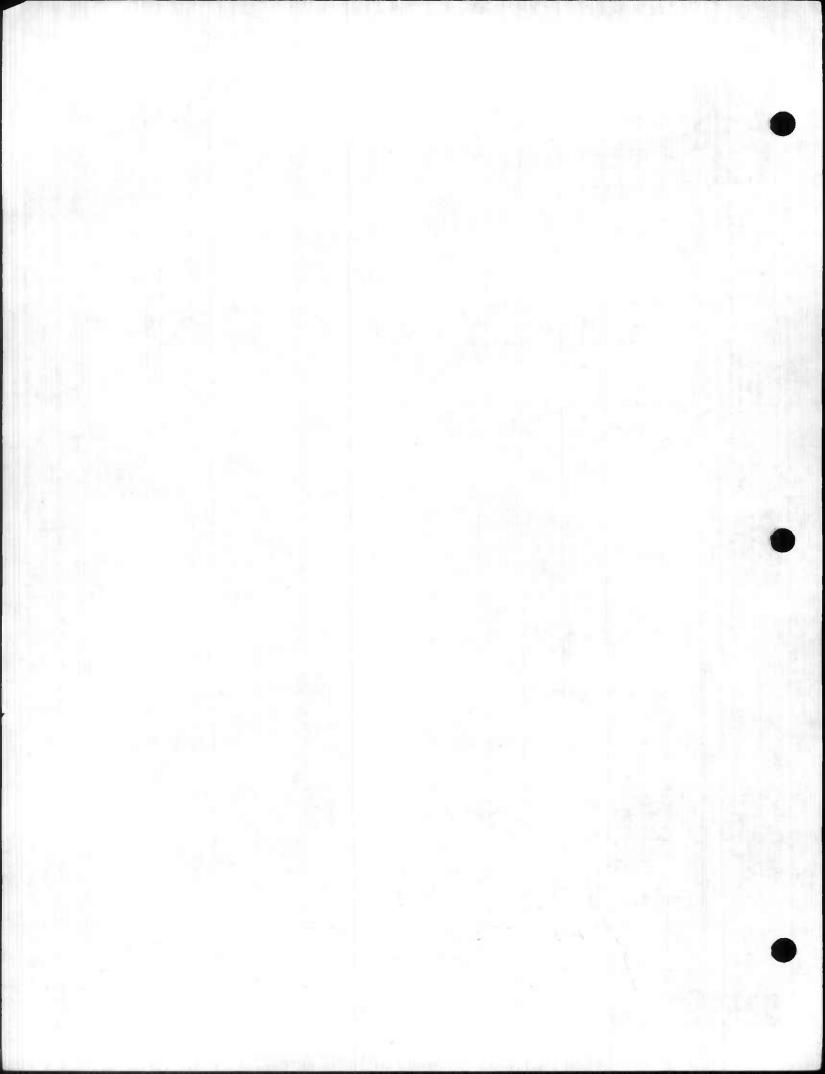
State

Registrar

31. Dete filed (Month, Day, Year)

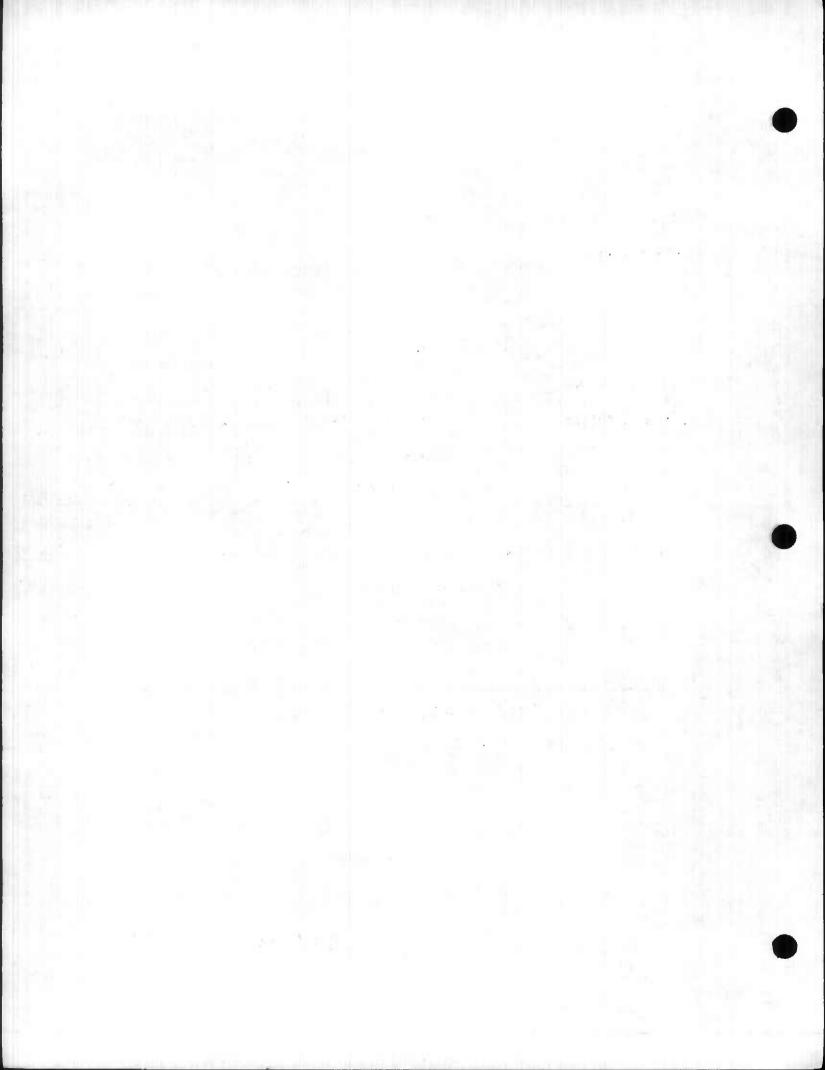
JUL 29 1999

32. Augistrer's Signature



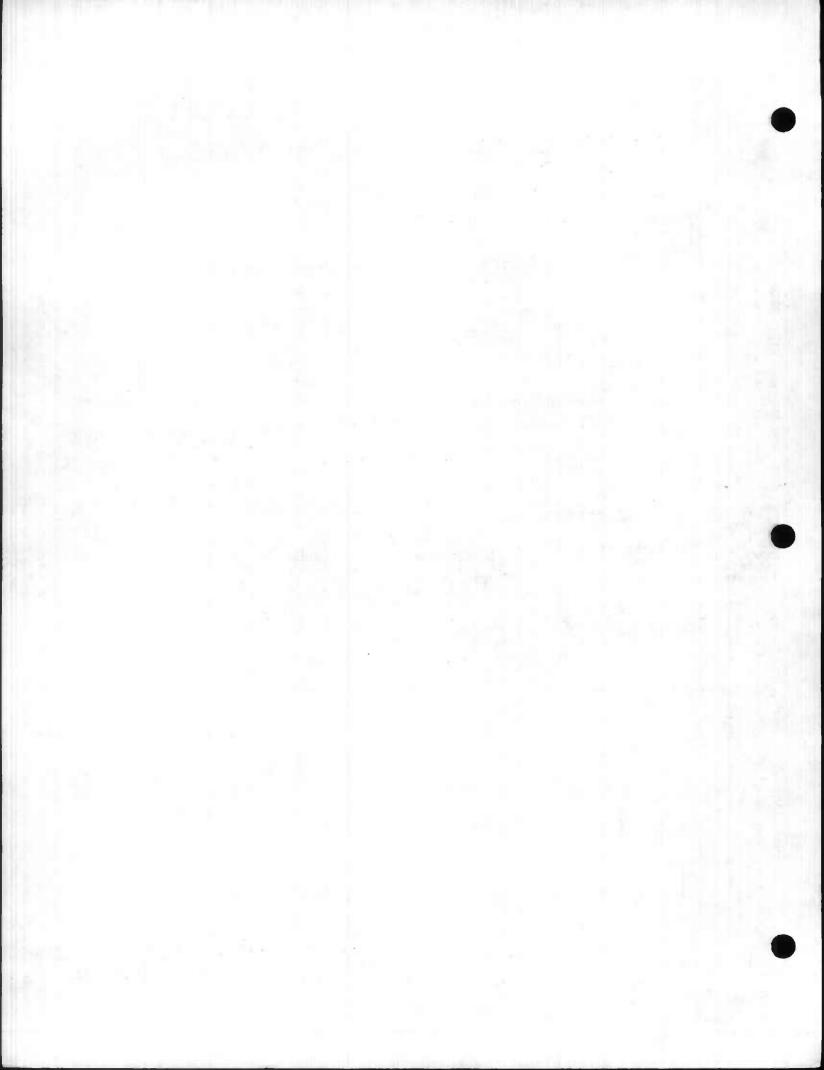
		State of Maryland / Department of Health and In Certificate of Death		leg. No.	25090							
	Physician /Medical	Robert L. Bullie	2. Data of Dea Month July	Day	3. Time of Death 999 9:30 AM							
	Examiner Funeral Director	As Franklin Name (Mant franklin also also attend and a section)										
	yland	Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location		, 23 10 12	10d. Inside City Limits							
	vith the Mar or 28a-fall be notified	Maryland Montgoemry Rockville 10e. Street and Number 10f. Zip Code	1	I0g. Citizen of Wh	1 ☐ Yes 2% No nat Country?							
	within 72 hours after death with the Maryland sins. then 'netural', or fleme 23a or 28a-f show fre Medical Example court by motified at promised by Funeral Director			USA 14. Race - Bleck.	- Amarican Indian, Whita, atc.							
-0020	hours after tural, or h	3 ☐ Wildowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify:	African American							
Maryland 21215-0020	L - U	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Intelligence Officer	king		ent of Defense							
ryland	should be filed and Mental Hygien I marked other umatic avent, tr	17. Father's Nama (First, Middle, Last) Willie L. Bullie Jessie N	1. Benne	Maiden Surname) t t								
0	Health a market health a marke		ockville Date Lug 1	MD 20 20c. Location - C	853 ity or Town, Stata							
Baitin	permit. Pages Department of Important: If it any injury or o	21. Signetury of Funaral Service Licensee 22. Name and Address of Facility Francis J. Collins 500 University Bly	Funera	Silver S	Inc.							
A	Physician /Medical Examiner	23a. Part1 Enter the disease, or complete for sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition rasulting in death) Severe malabsor phon Due to (or as a consequence of):										
Φ	certificate be associated digns physician and use as the burial-fransit	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			3 years							
O. Box	es that the death certification of the estending be detached for use as by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use centribute to the cause of death									
C.		Crist State Worker Tollitotic	1 🗆 Y	an autopsy	24b. Ware autopsy findings available prior to							
	The law ate has be page 2 s		1 D Y	es 219 No	completion of cause of death?							
Division of Vitai	To the Hospital or Attanding Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	1 Yas 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	28d. Describe h	ence 6 Other ow injury occurred								
_	To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce	29a. Cartifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the control	, and due to the c rred at the time, c	ause(s) and mani late and place, an	ner as stated. d due to tha cause(s)							
	to the second of	29b. Signature and titla of certifier 29c. License number D52299 30. Name and address of person who completed gause of death (ttem 23a) (Type, Print)		29d. Data signed ((Month, Day, Year) 8/99							
ľ	State Registrar	31. Date filed (Month, Day, Year) JUL 30 1999 32. Registrar's Signature 4. Locally	bring	MD	20904							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99 25091

					C	ertificat	e of	Death			Reg. No.	1 6.	. JUS			
		1. Decedent's Nama (First, Middl	e, Last)							2. Data of De		Mana	3. Tima of	Death		
Physi- /Med		Bernard E. Bui	rr							Month July			3:15	PM		
Exam		4a Facility Nama (If not institution		number)				4b. City, To		ocation of Deatl						
10		Carriage Hill	of Beth	esda				Bethes	sda		Montgo	merv				
Funera	1	5. Social Security Number	6. Sex	7. Age (in yrs	s. last birtho		r 1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da			laca (State of	Foreign		
Directo		188-03-9434	1 (3kM 2 □ F	92	Yrs	Months.	Days	Hours	Min.	Jan. 2						
0		Usual Rasidence of Decedent														
thow the		10a. State 10b. County		10c. C	city, Town o	r Location						1				
h The Marylan r 28a-f show unotified at	oto	Maryland Montgo	mery	Betl	nesda								1 🗆 Yas	2⊠ No		
(i) (i) (ii) (ii) (ii) (ii) (ii) (ii) (Dire	10e. Street and Number				10f. Ziç	Code				10g. Citizen of V	/hat Coun	ntry?			
23 a		4700 Chestnut S	treet			208	14			1	JSA					
8 89	Funeral	11. Marital Status		ecedent Ever in Forces?	U,S.	13. Was Dece	dent of I	lispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14. Rac					
0 4 40		1 ☐ Nevar Married 2 ☑ Marr		s 200No		1 ☐ Yes			, 1 0010	Tioan, otc.)						
5-0020 72 hours after netural, or to fical Examina	by	3 ☐ Widowed 4 ☐ Divorced	Year or			111105	2 LANVO	эрвску.			Specify	: WILL	Le	7		
5-00 72 hour float Ex	Completed	15. Deceden (Specify only higher	t's Education	d)	16a. De	ecedent's Usu	al Occup	pation	t of work	ina	16b. Kind of Bu	sinass/Inc	dustry			
F2	d.	Elemantary/Secondary (0-12)	T	(1-4or 5+)	- 'lii	ive kind of wo le. DO NOT u	se retire	d)	or work	".9	Nationa	1 Ins	stitut	e of		
Manager 17	00		5+		Bio	-Chemi	st				Hea1	th				
Maryland 21215-0020 of a should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or transmitte event, the Medical Exam.	Be	17. Father's Neme (First, Middle,	Last)					18. Mothe	r's Name	e (First, Middle,	Maiden Sumam	Θ)				
Viant Want		David E. Burr						Rebec	ca F	R. Burgi	ner					
Age and and send send send send send send send se	100	19a. Informent's Neme/Relations	hip (Type, Print)		19b. M	lailing Address	s (Street	and Number	er or Run	al Route Numb	er, City or Town,	State, Zip	Code)			
_ 2002		Edna C. Burr /	Wife		470	0 Ches	tnut	Stre	et,	Betheso	la, MD	2081	4			
altimore, mit. Pages 1: partment of He portant: if Nem y Injury or othe		20a. Mathod of Disposition	- 00		Place of Di	isposition (Na	me of		1	Date		City or To	own, Stata			
Pages sent of nut. If the rry or o		1 ☐ Burial 2√√Cramation 4 ☐ Donation 5 ☐ Other (S				litan				July 27	Aloxand	ri o	37 A			
altin		21. Signatura of Funaral Sarvice	Licensee		J G Z G P G	22. Nama ar	nd Addre	ss of Facilit	У				VA			
m 88158	1	1. Ken Stiles														
			complications tha	t caused the dea	eth. Do not	enter the mod	1Ve1	rsity	BIVO	or respiratory a	Silver S	pring	Approximate	20901		
Physician		23a. Pafi1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Betwee Onsat and Deat														
/Medica		Immediate Causa (Final diseasa or condition rasulting in daath) a. Hypertusive heart Disease														
Examine																
	ě															
68760, tificate be executed ig physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying															
ower in an infaltr	Exa	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying														
5x 68760, certificate be executed nding physician and use as the burial-transit	edicai	Cause (Diseasa or injury that initiated events	C	Hell	6	Lyal sequence of):		-ail	40	1						
fice the phy		rasulting in death) Last				sequence or).	1 0	1 - 1-	. 0							
	3		d	Dialu	lie	3 10	lel	lit	us	^						
death cer death cer e ettendin ed for use	cla									1						
P.O.	Physician	Part II. Other significant condition	ns contributing to	death but not re	sulting in th	e underlying o	ause gi	ven in Pert I						_		
P.O. that the detech	4									10	Yes 2□ No	y Year 1999 3:15 PM County of Death Intgomery 9: Birthplaca (State or Foreign Country) 07 Russia 10d. Inside City Limits 1				
of Vital Records, P.O. Box Physician: The law requires that the death cer this certificate has been signed by the ettendir ral director, page 2 should be deteched for use	d by									24a Wes	an autopsy	3. Tima of Death 3: 15 PM 4c. County of Death 3: 15 PM 4c. County of Death Montgomery 9. Birthplace (State or Foreign Country) 1907 Russia 10d. Inside City Limits 1				
Per regulation	ete										med?	10d. Inside City Limits 1				
Rec elaw has t	Completed										,	of	deeth?			
The steep	S									10	Yas 2 No	1[☐Yas 2☐	No		
f Vital Reysteien: The Les certificate hadrector, page	Be	25. Wes casa rafarred to medical axaminar?	-						of Deet	h (Check only o	one)					
of Vita Physician: rithis certific oral director,	ပို	1 Yas 2 1No			☐ ER/Outpa	atient 3 D	OH OH	her: 4BNu	ırsing Ho	me 5□Resi	dence 6 DOth	er (Specif	(y)			
To Profit		27. Menner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Dat	le of Injury onth, Day Year)	28b. Tim Inju	a of	2Bc. Inju Wo	ry at		28d. Describe	how injury occur	ed				
Division or Attanding after death. Director: After d in by the fune	atic	2 ☐ Accident invastig	gation		- "	M	1	Yes 2	No							
Am Am	the state of the s	3 Suicide 6 Could a detarm	ined 200. Pla	ce of Injury - At I	home, farm	, street, factor	y, office			28f. Location (. City or Tor		er or Rura	al Route Numi	ber,		
O Saga	Certification:)			.,,											
hour Ineri	ie l	29a. Certifier 1 Certifyin	g Physician: To the	he best of my kn	owledge, d	eath occurred	at the ti	ma, dala an	d place,	and due to the	cause(s) and ma	nnar as si	tated.			
n 24 Piete	edical	one)		anner stated.	ation ario/o	rinvestigation	, in my o	opinion, dee	tn occur	ed at the time,	date and piece,	ing gue to	o the cause(s)			
Division or To the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Σ	29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year)														
10		I Tuoma	100.Vc	Sept			00	473	33	0	72	119	9.			
10		30. Name and address of person		use of death (Ite	m 23a) (Tv			-			-	-				
		50 W. Ed	mered	m Do	IVA	. 1	-0 C	Ruil	1	. M	1 20	8 5	52			
S	ate	31. Data filed (Month, Day, Year)	32.	Registrar's Sign	natura											
Regis	_	JUL 2 8 19	399 2	Breve	19	do	1	/								



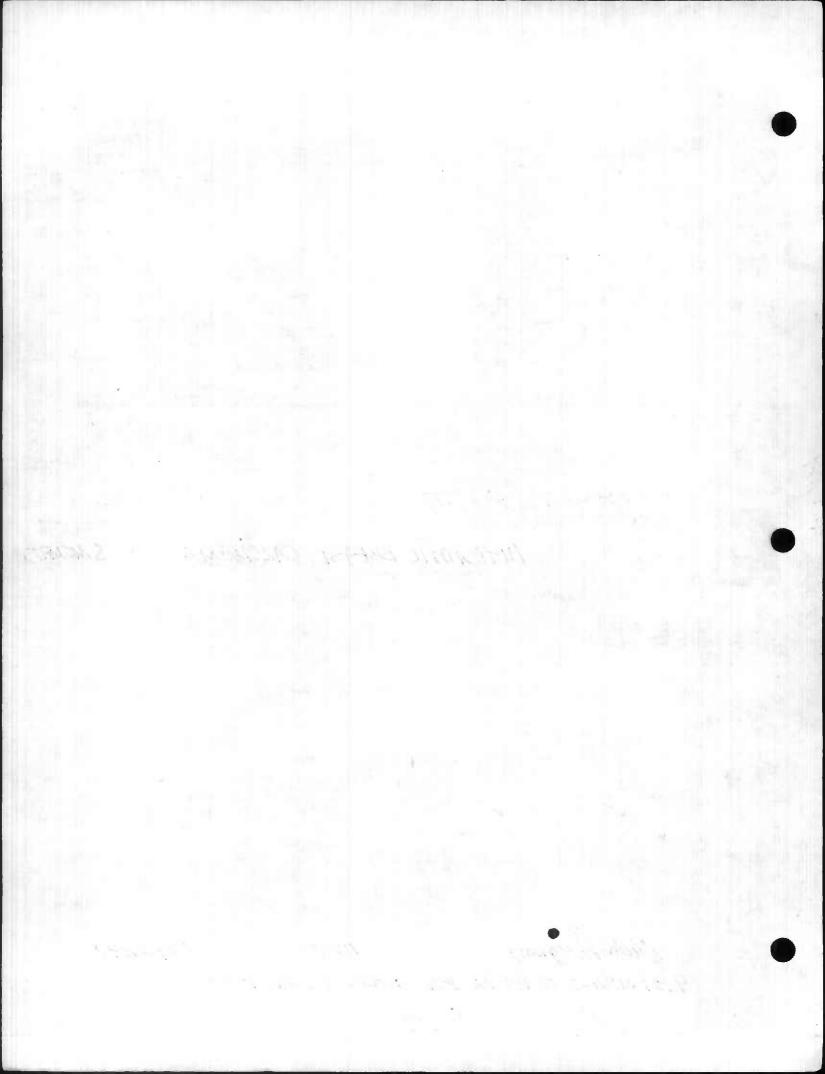
State of Maryland / Department of Health and Mental Hygiene

To Be Completed by Funeral Director To Be Completed by Funeral Director	suel Residence of Decedent De. State 10b. County De. Street and Number 1215 Ingraham 1. Marital Status 1 (X Never Married 2 Merried 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest g Elementery/Secondary (0-12) 7. Father's Neme (First, Middle, Las Arthur 0 9a. Informent's Name/Relationship Raymond Burriss Decedent's S Decedent's	St., N.W. 12. Wes Decedent Ever Armed Forces? 1 Yes 2 X No Yes Calculation rade completed) College (1-4or 5+) 5 12. Wes Decedent Ever Armed Forces? 1 Yes 2 X No Yes Calculation rade completed)	in U,S.	day) If Under Months or Location ington, 10f. Zig 13. Was Decedent's Usu	D.Coode 2001 dent of Herity Cuba 201No	I ispanic Origin? (S n, Mexican, Puert	B. Date of Birt (Month, Dej March	4c. County of MONT(MONT(4, 1945)	Joseth GOMERY 9. Birthplace (State or Foreign Country) Jashington, D. C			
To Be Completed by Funeral Director To Be Completed by Funeral Director To Be Completed by Funeral Director	SUBURBAN HOSPIT Social Security Number 578 60 7531 suel Residence of Decedent De. Street and Number 1215 Ingraham 1. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced (Specify only highest gr Elementery/Secondary (0-12) 7. Father's Neme (First, Middle, Las Arthur O 9a. Informent's Name/Relationship Raymond Burriss Decedent's S Anthur O 9a. Informent's Name/Relationship Raymond Burriss Decedent S Decedent's S Decede	St., N.W. 12. Wes Decedent Ever Armed Forces? 1 Yes, Give Year or Dates: ducation rade completed) College (1-4or 5+) 5+	54 Yr C. City, Town of Wash:	ington, 10f. Zig 13. Was Deceif Yes, spe 1 Yes	D.Coode 2001 dent of Herity Cuba 201No	BETHES If Under 24 Hrs. Hours Min. I ispanic Origin? (Sin, Mexican, Puerle	B. Date of Birt (Month, Dej March	MONTO 14,1945 W	GOMERY 9. Birthplace (State or Foreign Country) Vashington, D. Country 10d. Inside City Limits 1 \times Yes 2 \subseteq No nat Country?			
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19	Arthur O 9a. Informent's Name/Relationship Raymond Burriss 1 Method of Disposition 1 Method of Disposition 1 Method of Disposition 3	*		anageme	nt A		ne (First. Middle.	U.S. Go Maiden Surname	vernment			
204	Raymond Burriss Da. Method of Disposition 1 \(\times \) Burial 2 \(\times \) Cremation 3							ne Burri				
20d and Am	Da. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		19b. I	Meiling Address	s (Street	and Number or Ru	ral Route Numbe	r, City or Town, S	itate, Zip Code)			
ury or o	1 ⊠ Burial 2 □ Cremation 3					od Ln.,F			aryland 20744			
25	4 □ Donation /5 □ Other (Spec	Removel from Stele	cemerery,	cremetory or only Memor	orner piec		31/99		r, Maryland			
	1. Signaturo (1) Fugera) Service (10)	Wille The State of	the					W., Washington, D.C. 20012 espiretory errest, Approximate Interval Between Onset and Death				
ciar, dical diner di re-	Immediate Cause (Final disease or opedition resulting at death) a. METASTATIC BREAST CARCINOMA Due to (or as a consequence of): Sequentially list conditions.											
edical cutte	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events soutling in death) Last	C. Due										
sician/M	art II. Other aignificant conditions	contributing to death but no	t resulting in t	he underlying o	ause give	en in Part I.	23b. Did t	obecco use confi	ribute to the cause of death			
d by Physician/N	•					77.111.410.4	101	,	3 Probably 4 Unknow			
2 shou								an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?			
Сош							101	es 28/40	1□Yes 2□No			
o Be Comp	5. Was case referred to medical examiner?	Hospital:	022-20-5	- 10.400	. Oth	44	th (Check only o					
- F	1 Yes 20 No T. Manner of Death 1	28s. Date of Injury (Month, Day Ya	2 ER/Outp 28b. Tin Inji	SCHOOL SERVICE	28c. Injury World	4 L.J reumang H	Physics Service Services	lence 6 Other now injury occurre				
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							Street and Number m, State)	r or Rural Route Number,			
	9a. Cortifier 1☐ Certifying P (Check only 2☐ Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.	knowledge, omination and/	death occurred or investigation	at the tim , in my or	ne, date and place pinion, death occu	, and due to the orred at the time,	ceuse(s) and man date and place, ar	ner as stated. nd due to the cause(s)			
d ≥ 29	6. Signature and title of certifier		e number		29d. Date signed	(Morth, Day, Year)						
	Mida free		07/27	199								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDICAL CEMEN DN #30 NOCKNUE, MD 20850											

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Buckiss Babaca



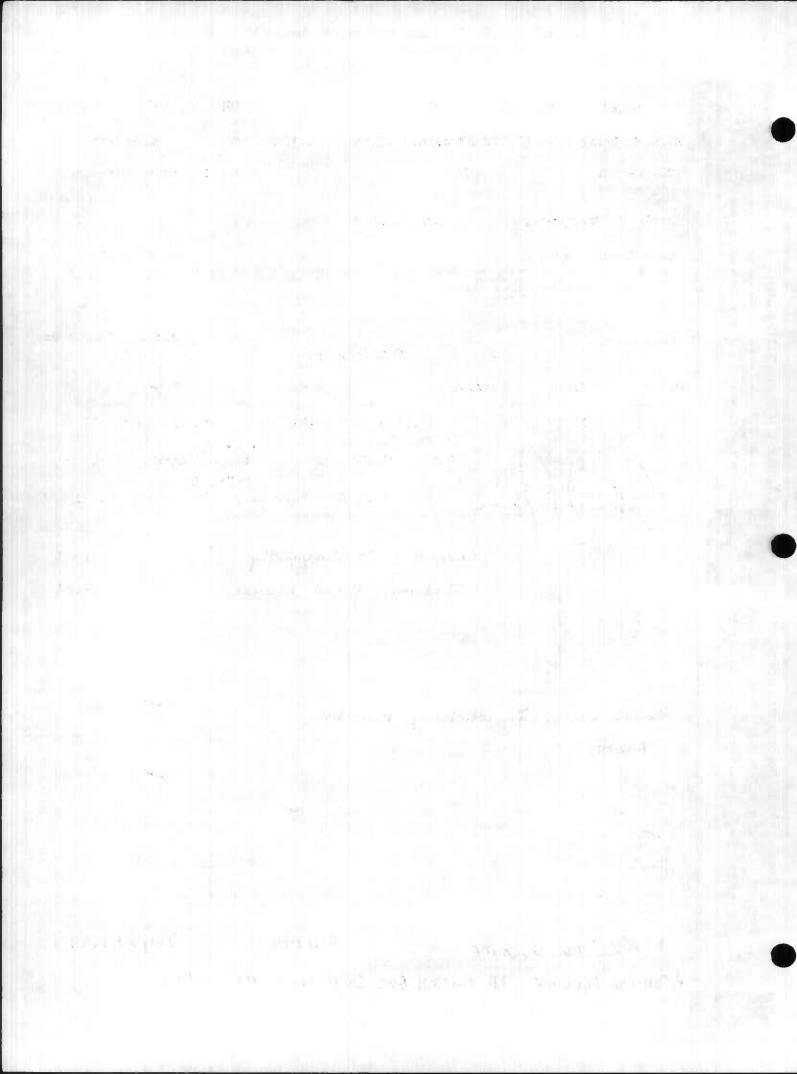
State of Maryland / Department of Health and Mental Hygiene 0

	_					Ce	rtificate	of L	Death		F	leg. No.	- (. 00	20		
Physician	1. Dece	dent's Name (First, Mic	die, Lasi	t)							Date of Dea Month	th Day	Year	3. Tim	e of Death		
/Medical		HARRY WILLIAM BURRUSS 4a Facility Name (If not institution, give street and number) WILSON HEALTH CARE CENTER AT ASBURY VILLAGE GAITHI									JULY 2	5, 1999		10:	15 PM		
Examiner	4a Faci	ity Name (If not institut	ion, give	street and num	ber)			4	b. City, To	wn, or Loc	ation of Death	4c. County	of Death				
	WILS	SON HEALTH	CARE	E CENTER	R AT AS	BURY	VILLAGE		GAIT	HERSB	URG	MON	TGOM	ERY			
ıneral	5. Socia	Security Number	6. Se		7. Age (In yrs.	last birthday	If Under 1 Months	Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (Sta	ite or Foreig		
ector	198-	-28-0822	15	7M 2□F	94	Yrs.		,-			Oct 18	1904					
		esidence of Decedant	4		10- 0	h. Your out		-						40.4 1 44	- On - 11 - h		
ef, or tems 23a or 28a-f show Exercises must be notified at by Funeral Director	10a. Sta					ty, Town or L											
iner must be noutre. Funeral Directo	Mary	land Mont	gome	ery		Saithe	rsburg							X	res ZUN		
Sire Sire	10e. Str	eet and Number					10f. Zlp C	ode			1	log. Citizen of	What Cou	ntry?			
1 18	1661	3 Alden Av	enue	2			12.51	208	377			United	Sta	tes			
i e	11. Mari	tal Status		12. Was Dece	dent Ever in U	J,S. 13.	Was Deceder	nt of Hi	ispanic Ori	gin? (Spec	city Yes or No-				٦,		
图 正		Never Married 2∑ M	being	1 ☐ Yes	2K No		1 ☐ Yes 20		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ato.			
	3 🗆	Widowed 4 ☐ Divorce	ed	Year or Da	tes:		10100 20	A	орвону.			Specif	wh	ite			
Completed		15. Deced (Specify only high	ent's Edu	ucation		16a. Dece	edant's Usual (Occupi	ation	t of workin	0	16b. Kind of B	usiness/li	ndustry			
aldi	Eleme	entary/Secondary (0-12	-	Collega (1-	4or 5+)	life.	DO NOT use	retired	f)	CO POINT	9	Nation	al Ir	istit	utes		
traumatic event, pre Modesal				3		C1	nief Py	rog	gen			of H	ealtl	1			
Be	17. Fath	er'a Name (First, Middl	a, Last)						18. Mothe	er's Name	(First, Middle,	Maiden Sumar	ne)				
To	Hary	y Will	iam	Bur	russ				Mary	У	С.	Schey					
		ormant's Name/Raiatlo	nship (T	ype, Print)		19b. Mai	ing Address (S	Street	and Numbe	er or Rural	Route Numbe	r, City or Town	Stata, Zi	p Coda)			
rt.	Thon	as Hays Bu	rrus	s, Sor	1	155	25 Part	ner	ship	Rd	Pooles	sville.	MD	2083	7		
6					Section 19 1	Place of Disp	osition (Nama	of			Data			own, State	a		
y or	112	Burial 2 Crematio	3 DF	Removal from S	tate							Cadaba	h	W	TD.		
ž ,					FOL				,	h.							
SDC	21.50	Tuly 30, Forest Oak Cemetery 1999 Gaithersbur 22. Name and Address of Facility DeVol Funeral Home															
		22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and or heart failure. Usit only one cause on each line.															
	23a. Pa																
ian															ind Death		
lical	disease	ata Cause (Final or condition			(000	avitro.	card	las	M 0.00	H.			1	11-6cm	2		
ner	resulting	g in death)		а	Due to (or as a conse	caud		7-10	4				1			
Examiner	Ischemie Heart Viscouse												11001	20			
tha bunel-transit dical Examir	Sequen	tially list conditions.		b		or as a consa			, 0,					100			
	if any, le	tially list conditions, eading to Immediata Enter Underlying											i				
edical	Cause (Enter Underlying Disease or injury ated events	5	C	Due to (c	or as a conse	quenca of):					Birth Day, Year) Birth Day, Year) 8, 1904 Birthplace (State or Foreign Country) 8, 1904 10d. Inside City Limit 12 Yes 2 No 10g. Citizen of What Country? United States No- 14. Race - American Indian, Black, White, atc. Specify: White 16b. Kind of Business/Industry National Institutes of Health The, Maiden Surmame) Schey Inber, City or Town, Stata, Zip Coda) esville, MD 20837 20c. Location - City or Town, Stata Gaithersburg, MD Funeral Home thersburg, MD 20877 Approximate interval Between Onsat and Death Yearst, Interval Between Onsat and Death Yearst Index 2 No Yearst Index 2 No Index					
for use as the burie clan/Medical E		in death) Last											į				
M				d													
Physician	Part II C	ther significant condi	tions co	ntributing to des	ath but not res	sulting In the	underlying cau	es niv	en in Part i		23h Did to	ohacco use co	ntributa	to the cer	se of deati		
ache hys									on mit die	•		Gaithersburg, MD ol Funeral Home Gaithersburg, MD 20877 Paratory arrest, Approximate Interval Between Onsat and Death Queval Approximate Interval Between Onsat and Death Approximate Interval Between Onsat					
be det by P	0	monic yea	avo	Insi	AR Che	nay	Devend	ia				2010		,			
						91					24a. Was a	an autopsy	24b. V	Vara autor	sy findings		
should		AMWHS									perfor	med?	0	ompletion			
paga 2 should															29.5		
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Be		case referred to medioniner?	_	Manahati				100		of Daath	(Check only o	na)					
F 6		Yas 20 No				ER/Outpatie			4 CINU	-				ify)			
in by the funeral dertification: To		ner of Death Natural 5 ☐ Pend	lina	28a. Date o (Month	Injury , Day Year)	28b. Time Injury	of 280	. Injun	y at k?		8d. Describe h	ow injury occu	rred				
completely filled in by the funeral Medical Certification: 1	2 🗆	Accident Inves	stigation				М	10	Yes 2	No							
# 6		Suicide 6 ☐ Coul Homicide data	mined	28a. Placa	of tnjury - At h	ome, farm, s	treet, factory, o	office		2			ber or Ru	ral Route I	Number,		
Çe					3, (-)	,,											
iai (29a. Ce	rtifier 1 Certify	ing Phy	sictan: To the t	est of my kno	wledge, dea	th occurred at	the tin	na, data an	d placa, a	nd dua to tha	ausa(s) and m	annar as	stated.			
edicai		e) 2 Medica	it Exami	nar: On the bas and mann	sis of examina er stated.	ition and/or l	nvastigation, in	my o	pinion, daa	th occurre	d at the time, o	date and place,	and due	to the cau	ise(s)		
×	29b. Sig	nature and title of certif	ier				29c. l		e number			-			ar)		
		PCON O Dak	V	dyon	N			DL	1179	4		July	27,1	999			
	30 No-	e and addrasa of parso	D who	ompieted source	of docth (tre-	m 23a) /Tun-	Print)										
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01		flied (Month, Day, Yes					2 Gai	116	-3000	1,		, ,					
State	JI. Date	med (MOHIII, Day, Yes	")	32. He	gistrar's Sign	ature /											

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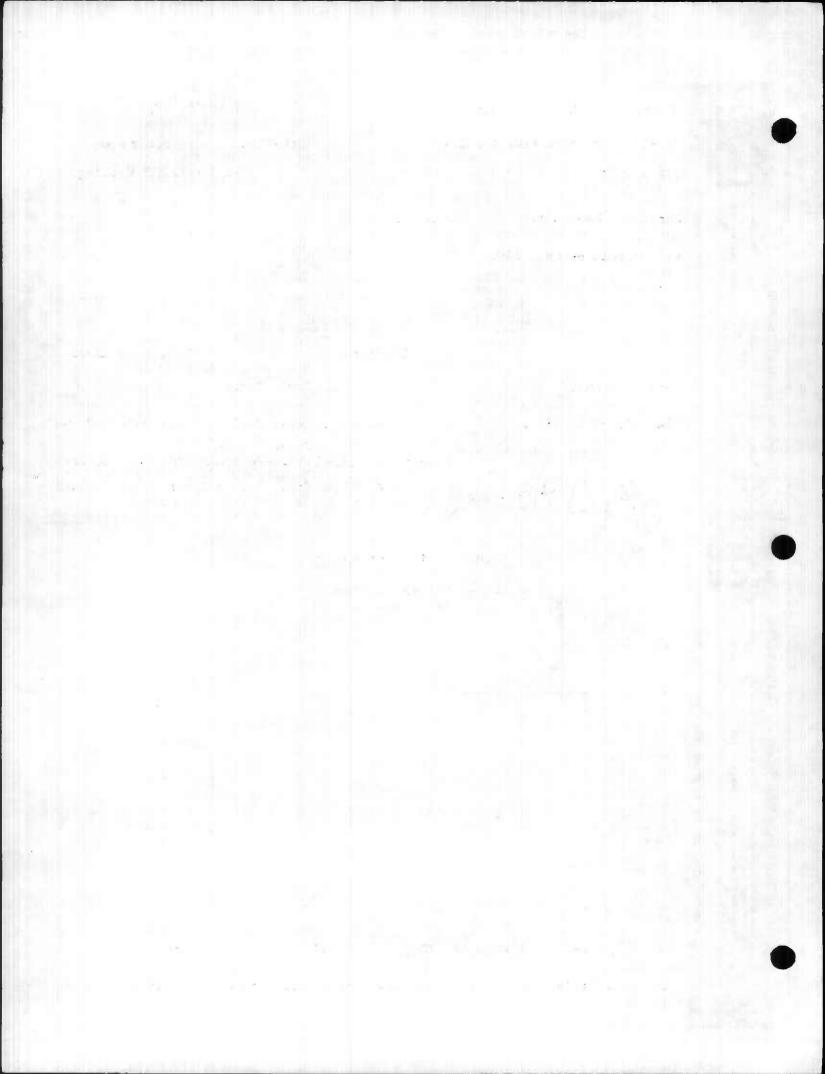
Registrar

JUL 3 0 1999



State of Maryland / Department of Health and Mental Hygiene 00 25001

				Certific	ate of	Death		Re	g. No.	la la	1094				
	1. Decedent's Nama (First, Middla,	Last)						ata of Death	Dey	Year	3. Time of Death				
sician edical	Florence L.	Butt						11y 28			10:54AM				
	4a Facility Nama (If not institution,	giva street and number)				4b. City, Tov	wn, or Location	n of Death	4c. County	of Death					
	Shady Grove Adv						ville		Mont	gomer	у				
or		. Sax 7. Ag	na (In yrs. last bi 79	Yrs. If Un Mont	dar 1 Yaar hs Days	If Under 2 Hours	Min /A	data of Birth Month, Day,	Year)	Count	lace (Stata or Foreign try) ington, DC				
-	578-32-5538 Usual Rasidance of Decedant		10			1	Dec	eliber 1	4, 1717	Wasiii	ington, be				
	10a. Stata 10b. County		10c. City, Tow	vn or Location						10	0d. Insida City Limits				
Funeral Director	Maryland Montgo	mery	Gaith	ersburg	5						1⊠Yas 2□No				
	10e. Street and Number			10f.	Zip Coda			10	g. Citizan of V	Whet Count	try?				
0	415 Russell Aver	ue, #402		2	0877				United	Stat	es				
1	11. Marital Status	12. Was Decedant Armad Forces?		13. Was De If Yes, s	cedant of I specify Cub	Hispanic Original, Maxican	gin? (Specify) i, Puarto Ricer	Yes or No- n, etc.)		ce - Amarica ck, Whita, a					
	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	f 1 ☐ Yas 2 ☒ If Yas, Giva Yaar or Datas:	No	1□ Yes	s 2 No	Specify:			Specify	y: Wh	nite				
	15. Decedant's (Specify only highast		16a	. Decedant's L (Giva kind of	work done	during most	t of working	1	6b. Kind of B	usinass/Ind	lustry				
	Elemantary/Secondary (0-12)	Cottega (1-4or	5+)	lifa. DO NO	T usa ratire	od)									
	-	1		Drafts	man	40. 84445	de Maria (Film		.S. Go		ent				
	17. Fathar's Nema (First, Middla, La Porter N. Butt	St)				Emma	r's Nama <i>(Fir</i> s Torre		aldan Suman	na <i>)</i>					
	19a. Informant's Name/Relationship	(Tuno Brint)	10	b. Mailing Addr	one (Stron				City or Town	State 7in	Code				
	Clara M. Butt/ S	, , , , , ,									D 20877				
-	20a. Mathod of Disposition	TSCC1	20h Place	of Disposition /	Nama of		De	10 2	Oc. Location -						
	1 Burial 2 □ Cramation 3 4 □ Donation 5 □ Othar (Spe			ac United					Potoma	c Ma	ruland				
	21. Signature of Funeral Service to	^	TOLONE	22. Name	and Addr	ass of Facilit	Roberi	t A. P	umphre	y Fun	neral Home				
an cal in	Duffer / -) / / MAO	689	Rockv	ille,	Inc.	300 1	West M	ontgom	nery A	venue,				
	23a. Marry Enter the disaasa, or o	implications that cause	d the death. Do				aryland cardiec or ras				Approximete				
	Immediate Cause (Finel														
	diseasa or condition resulting in daath) Cardiorespiratory Arrest														
	diseasa or condition resulting In daath) a. Cardiorespiratory Arrest Dua to (or es a consequence of):														
	Metastatic Breast Cancer														
ı	Sequantially list conditions, if any, leading to immediate														
l	if any, leading to immediata causa. Entar Undarlying Causa (Disaasa or injury c.														
Causa. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in daath) Last Due to (or as a consequence of):															
ŀ		d													
	Part II. Other significant condition	contributing to death h	ut not resulting	in the underlyin	an cause of	van in Part I		23h Did toh	acco use co	ontribute to	the cause of death				
	tarn. Ottal algimoura condition	CONTRIBUTING TO GOATH E	at not resulting	in the dildeligh	ig oadse gi	TOTAL OIL					bably 4 Unknow				
								24a. Was an	autopsy	ava	era autopsy findings allable prior to				
										of c	mplation of cause death?				
								1 ☐ Ye	s 20 No	10	☐ Yas 2☐ No				
ŀ	25. Was casa rafarrad to medicat axaminar?					26. Placa	of Death (Ch	eck only one	9)						
	1 ☐ Yes 2 💢 No	Hospital: 1 Inpati	ant 20 27/0	utpatient 3	DOA		ursing Homa	5 🗆 Rasidar	nce 6 Oth	nar (Specify	v)				
	27. Mannar of Death 1 Natural 5 ☐ Panding	28a. Data of Inju (Month, Da	iry 28b.	Tima of Injury	28c. Inju			Dascribe hor	w injury occur	rred					
l	2 Accidant Invastiga 3 Suicida 6 Could no	the -		М		Yas 2 🗆					10 11 11				
l	4 Homicida datamin	28a. Place of in	ury - At homa, f c. <i>(Specify)</i>	arm, streat, fac	ctory, offica		281. [City or Town,	Stata)	per or Hura	il Routa Number,				
ŀ	29a. Cartifiar 1□ Certifying	Physician: To the best	of my knowledg	e daath occur	red at tha ti	ima data an	d place, and d	tua to tha ca	use(s) end m	enner as si	tated.				
		aminer: On the basis o	f axamination a												
ľ	29b. Signature and titla of certifiar		. /		29c. Lican	sa number		29	d. Data signa	ad (Month, I	Day, Year)				
1	I Cornol	7 Bend	14. m	0	D1761	.5		J	uly 28	, 199	19				
t	30. Neme and eddress of person w	no complated cause of o	death (ttem 23e)	(Type, Print)											
	Carol L. Bende				etown	Road,	Rockv	ille,	Mary1a	and :	20852-273				
	31. Deta filed (Month, Day, Yaar)	32. Ragisti	rar's Signature	, ,	,										
r	JUL 3 0 199	39	1	7. pp	outs	/									



State of Maryland / Department of Health and Mental Hygiene

				State of Ma	aryiar				Death	nemai ny	Reg. No.) 2	25095			
	Physici	an	1. Decedent's Name (First, Middle, La	st)		n. I.	1			2. Date of De Month	Dey	Year	3. Time of Death			
R	/Medic		Frank			Balis	Tri		4b. City, Town, or L	July		199	13:45			
<i>J</i> ⁰	Examin Funeral Director	er	4a Facility Name (If not institution, given the Johns 5. Social Security Number 6. \$ 387-30-0376	Hopkin	uls 67	HOS last birthday) Yrs.	If Under	er 1 Year	D 11	8. Date of Bi		9. Birthp	olace (State or Foreign			
			Usual Residence of Decedent		10.01	-				Debr	1201					
	aho	۲	10a. State 10b. County			ty, Town or Lo							1 ☐ Yes 2 ☑ No			
	the N	Director	MD Anne Ar	uriaer	A	nnapol:	1	ip Code			10g. Citizen of W	/hat Cour	**			
	death with the Maryland me 23a or 28a-f show cmust be notified at		1008 Lake Clair	9				1401			USA					
	death	Funeral	11. Meritel Stetus	12. Wes Decedent 8 Armed Forces?	er in U	,S. 13. V	Ves Deci	edent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No)- 14. Race	- Americ	can Indian,			
020	72 hours after deal natural", or frems	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo		□ Yea		Specify:	moan, otc.)	Specify:					
0200-91212		Be Completed	15. Decedent'a Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	tife. L	kind of w DO NOT	ork done use retired	during most of world)	ing	16b. Kind of Bu					
	filed within Hygiene. ther then	ပိ	17. Father's Name (First, Middle, Last,	2		Ac	dmin	istra		e (First, Middle	Heal Maiden Sumam		re			
au	る草色ラ	o B	Salvatore Balis							ine Dit						
Maryland	shound M	-	19a. Informant'a Name/Relationship (Type, Print)		19b. Mailin	g Addres	s (Street	and Number or Rus	ral Route Numb	er, City or Town,	State, Zip	Code)			
	and 2 belth e n 27 is		Carn Farrell/Day	ughter		170	011	Com F	ox Ave.	Pooles	ville, M	D 20	837			
altimore,	Peges 1 nent of H nt: If Iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control		20b. F	Place of Dispos cemetery, cren Metro	natory or	otrier plat	(90)	uly 28	20c. Location -					
Balt	permit. Departminenta importa any inju		21. Signature of Funeral Service Licer	5	1	E	Barra	anco	& Sons,				uneral Home			
			23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Betwee Onset and Death.													
	Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death) Subarachnoid hemorrhage M													
	EAG.	ē	resulting in death)		Due to (or as a conseq			J				LOE I ST			
	cate be executed physician and sthe burial-transit	Examiner														
09/99	centificate be executed nding physician end use as the bunal-transit	edicai	Cause (Disease or injury that initiated eventa resulting in death) Last													
ZOX POX	the st	ian		d												
	the d	Physician/M	Pert II. Other significant conditions of	ontributing to death bu	t not res	ulting in the un	nderlying	cause giv	ven in Pert I.		Yas 2 No		o the cause of death?			
-	s that and b	by P									22710					
Hecc rds,	law requires that as been signed to 2 should be det	Completed									s an autopsy ormed?	av cc	fera autopay findings vailable prior to completion of cause death?			
	ilcien: The lav certificate has rector, page 2	mo.								10	Yes 2MNo	tl	□Yes 2□No			
VII S	stan: artifica ctor, I	Bec	25. Was case referred to medical axaminer?						26. Place of Dea	th (Check only	one)					
	Phyalclan: r this certific ral director,	2	1 ☐ Yea 2 図 No	Hospital:		ER/Outpatien			4 LI Nursing H		idenca 8 DOthe		fy)			
DIVISION	To the Hospital or Attending Physician: The is within 24 hours after 06ath. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b		Year)	28b. Time of Injury	М	28c. Injur Wor 1 🗆	rk? rk? Yes 2 □ No	28d. Describe	how injury occurr	ed				
	tal or Att is after of al Direct ed in by	Certifi	3 Suicide 6 Could not b 4 Homicide determined			(Street and Number own, State)	er or Run	al Route Number,								
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	29e. Certifier (Check only one) 29e. Certifier (Check only one)														
	To the Tour Comp	×	29b. Signature and title of certifier				25		se number		29d. Date signed (Month, Day, Year)					
			It- sin	M.D. NO	cu	Fellow	1	RES	5-000		July 27	, 19	99			
			30. Name and address of person who W. Ziai M.D.	Johns Hop		105011	Print)	600	N. Wolfe	St. 84	Hmore	MD	21287			
	Sta Registr		31. Date filed (Month, Day, Year) JUL 3 0 199	32. Registra		ature 4	1	~ ~	,		1					

The first of

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of Vital

\$ 40

29b. Signature and title of cartifier

and.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LINDA M. BURRELL, 2101 MEDICAL PARK DRIVE #210, SILVER SPRING, MD 20902 31. Date filed (Month, Day, Year) 32. Registrer's Signature JUL 29 1999

29c. License number

1)35996

29d. Date signed (Month, Day, Year) 07.23.1999

State

Registrar

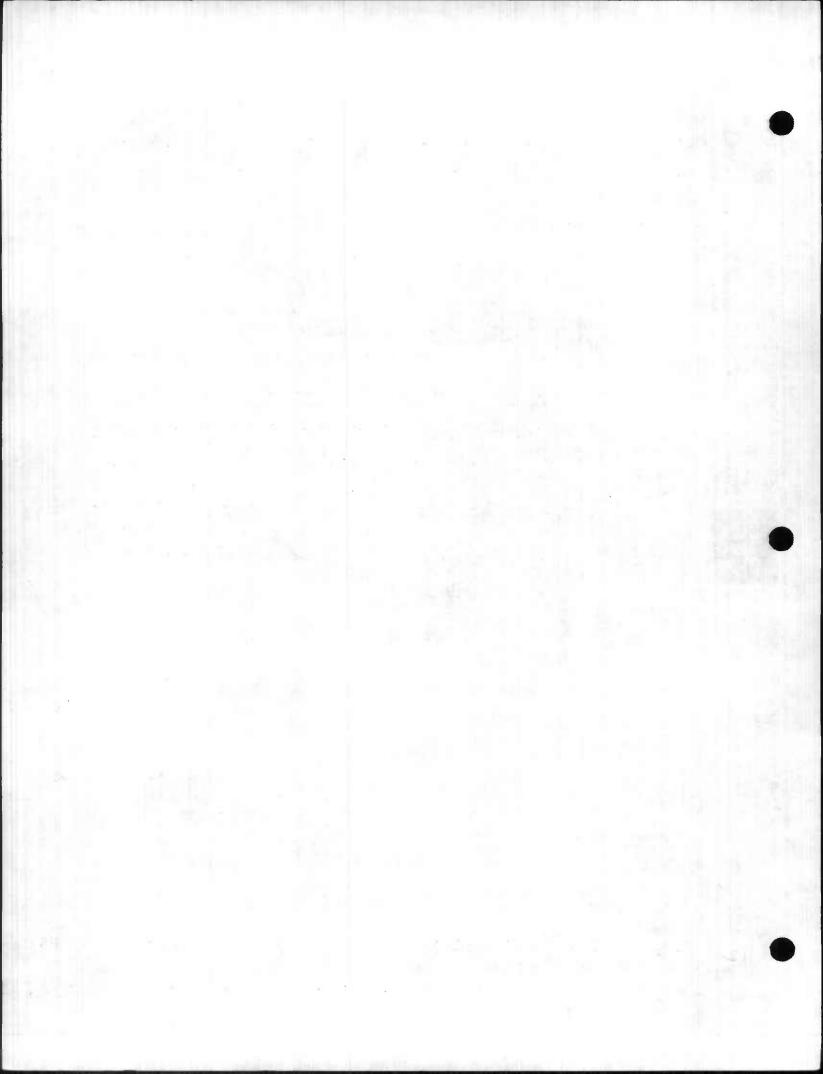
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ANS TEST 1410-1110-24

State of Maryland / Department of Health and Mental Hygiene

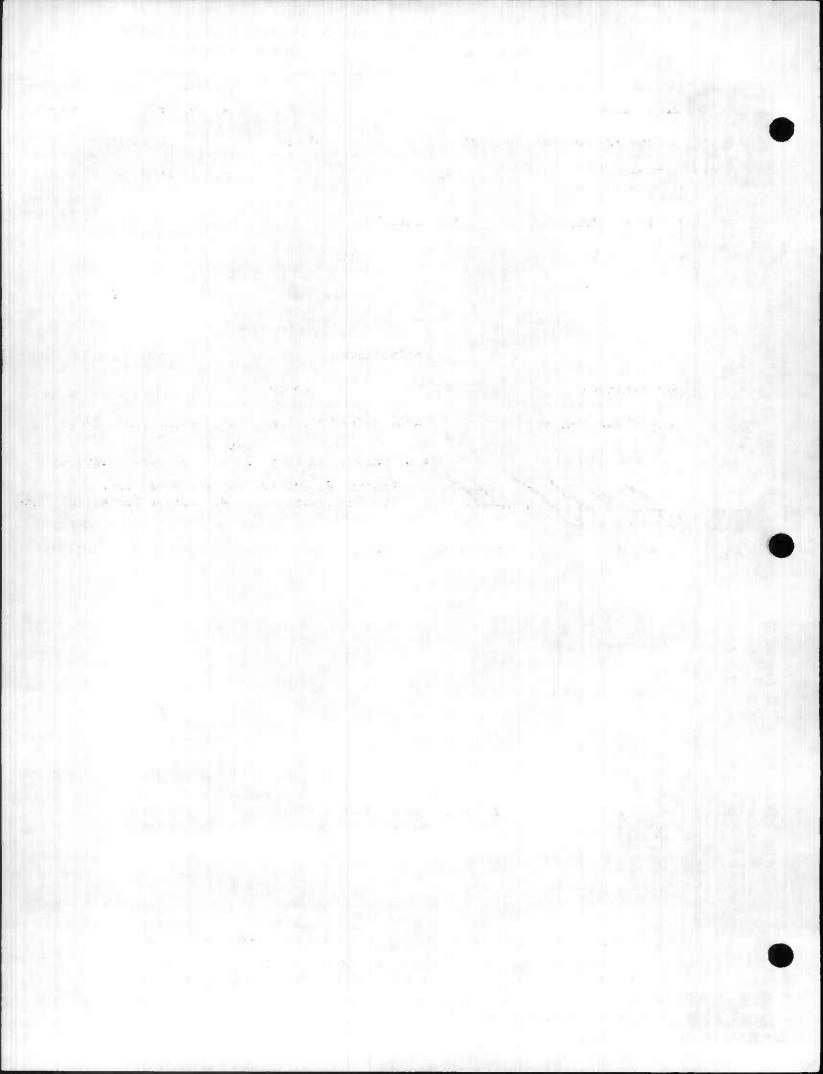
Certificate of Death

	Certificate of Death	Reg. No.	1 45097											
	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death											
Physician /Medical	Eleanor M. Cardwell	July 25, 1999												
Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Lo		y of Death											
91	1131 University Blvd. West Apt. #2105 Silver Sp	ring Monte	omery											
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)											
Director	218-16-2017 1 M 2 N F 75 Yrs. Morriers Days Prours Min.	July 29,1923												
2	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location													
anyle show	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No											
octo	Maryland Montgomery Silver Spring													
vith the Mai t or 28s-f si be notified Director	10e. Streef and Number 10f. Zip Code	10g. Citizen of	What Country?											
rai rai	1131 University Blvd. West Apt. #2105 20902	USA												
O Z1Z15-UUZU filed within 72 hours after death with the Maryland hygiene. ther than "natural", or fleme 23a or 23a-4 show mit, the Medical Earthon matter invitil and a Completed by Funeral Director	11. Mentel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto		ce - American Indian, ick, White, etc.											
S aft o	1 Never Married 2 Merried 1 Yes 2 No Nyes, Give 1 Yes 2 No Specify:	Speci	w. White											
ural', o	3 ☐ Widowed 4 ☑ Divorced Year or Dates:													
of within 72 hours at yolene. or than "natural", or it, the Wood of the Completed by I	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of E	Business/Industry											
d within jiene.	Elementary/Secondery (0-12) College (1-4or 5+)													
filed within the than the transfer transfer than the transfer transfer than the transfer tran	12 Plant Assignor 17. Father's Neme (First, Middle, Last) 18. Mother's Name	Telepho (First, Middle, Maiden Suma	ne Company											
Maryland 2 should be filed th end Mental Hyg 7 la marked other traumatic event,														
aryland 2 2 should be filed end Mental Hygi a marked other aumatic event, 8 To Be Cc		wellyn Milliga												
	t 9e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Run													
Heel Heel	Sandra M. Hartman / Daughter 1929 Cradock St., Silv	er Spring, MD	20905 - City or Town, Stete											
all LIMOre, mit. Pages 1 er partment of Hee portant: If Item; y Injury or othe	1 Buriat 2 Cremetion 3 Removel from State cemetery, cremetory or other place)	July 30												
tant: Pe	4 □ Donetion 5 □ Other (Specify) George Washington Cemetery	1999 Adelph	i, MD											
Demit. Pages 1 Department of P Important: if its any injury or of price.	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility	Funoval Hama	Too											
- 40 E # 4	Francis J. Collins Funeral Home, Inc. 500 University Blvd W., Silver Spring, MD 2 23e. Pentl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Interval Behw Onset and D													
Physician	111 1 1 1													
/Medical	Immediate Cause (Finel disease or condition resulting in death) a. Athlerosclembic Corunar	y Artery Dis	cess 10 years											
Examiner	resulting in deeth) Due to (or as a/consequence of):													
5 = G	- Hunertensin		10 years											
death certificate be executed eath certificate be executed eathending physician and of for use as the burial-trensit sician/Medical Examiner	Sequentially list conditions, Due to (or as a consequence of):													
Sian 2 Constitution of the	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury c.													
flicate be experience of physician as the burish edical E	that initiated events resulting in death) Last Due to (or as a consequence of):													
E 0 8														
et the death cert by the strendin etached for use	d.		1											
s des	Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did tobacco use co	ontribute to the cause of death?											
that the de ned by the statement of Physics		1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown											
E X D														
Physician: The law requires that this certificate has been signed to director, page 2 should be detail. To Be Completed by Pl		24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to											
law rate be 2 sh			completion of cause of death?											
The tay atte has page 2		1 ☐ Yes 2 No	1□Yes 2 No											
certificate rector, par	25. Wes case referred to medical 26. Place of Deat	h (Check only one)												
Physician: This certific rel director,	examiner? 1 Yes SerNo Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 58 Residence 6 🗆 Ot	her (Specify)											
Physical description of the second of the se	27. Menner of Deeth 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how injury occu												
Attending Indeath.	1 Selatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No													
l or Attending sher death. Director: Ahe d in by the fune entification		28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,											
ball or Attanding P is ster death. a) Director: After to din by the funeration by the funeration:	4 Homicide building, etc. (Specify)	Ony or Town, State)												
	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place,	and due to the cause(s) end m	nenner as stated.											
n 24 hou n 24 hou n Fune pletely fil	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, date and place	, and dua to the cause(s)											
Within to the transfer of the	29b. Signature and fitle of godfing 29c. License number		ed (Month, Day, Year)											
17-	D37975	Jul	424, 1555											
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
		Candas MD 00	001											
State	31. Dete filed (Month, Dey, Year) 32. Registrates Signatura	spring, MD 20	701											
Registrar	JUL 27 1999 Deneva B. Sparks													



State of Maryland / Department of Health and Mental Hygiene

				Certific	cate of	Death		Reg. No.	99	25098			
	1. Decedent's Name (First, Middle, Las	1)					2. Date of		Yaar	3. Time of Death			
Physician /Medical	Sros Chan						July	28, 19		4:45 am			
/wegical Examiner	4a Fscility Name (If not institution, give	street and number)				4b. City, Tow	n, or Location of D		County of Dea	ith			
	Montgomery General	l Hospital				01ney		Мо	ntgome	ry			
Funeral	5. Social Sacurity Number 6. Se	x 7. Aga	(In yrs. last birt		Indar 1 Year		4 Hrs. 8. Date of	Birth Day, Year)	9. Bir	rthpiaca (State or Foreig			
Director	218-08-6324	M 2□F	31	Yrs.	iins Days	Hours	Apr.	1, 19	68 Cam	bodia			
Q	Usual Rasidence of Decedent												
nylan how	10a. State 10b. County		10c. City, Towr	or Location	1					10d. Inside City Limit			
o Me	Maryland Montgome	ry	Burtons	ville						1 ☐ Yes 2 N			
or 28	10e. Street and Number			10	f. Zip Code			10g. Citize	en of What C	ountry?			
th wi	4204 Cedar Tree La	ne		2	0866			USA					
fier death with the Me r items 23s or 28s-f s increment be notified Funeral Director	11. Marital Status	12. Was Decedant E	var in U,S.	13. Was D	Decedent of h	lispanic Orig	in? (Specify Yas o Puerto Rican, atc.		4. Race - Am Black, Whi	ericen Indian,			
B 0 5	1 ☐ Navar Married 2 ☑ Married 3 ☐ Widowad 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ② N If Yes, Give Year or Dates:	0		es 2 🗓 No				Specify: A				
should be filed within 72 hours after and Mental Hygiene. marked other than "natural", or imatic event, or Medical Exami	15. Decedent's Ed	ucetion	16a.	Decedent's	Usual Occup	pation		16b. Kin	d of Business	s/Industry			
ple ple	(Specify only highast grad Elementery/Secondery (0-12)	ta completed) College (1-4or 5-	N	life. DO No	of work done OT use retire	during most	of working						
y with	Elementery/Secondery (0-12)	2		lescl	erk			Ret	ail				
Nentel Hygiene, arked other than attic event, tree.	17. Father's Name (First, Middle, Last)					18. Mother	's Name (First, Mid	ddle, Maiden S	(umeme)				
2 should be and Mentel is marked of eumetic every	Soeum Krouch					Chair	1						
d 2 should be file th and Mentel Hy ?? Is marked othe treumatic event To Be C	19a. Informsnt's Name/Relationship (7)	ype, Print)	19b.	. Mailing Ad	dress (Street	end Number	or Rural Route No	ımber, City or	Town, State,	Zip Code)			
end 2 sho leith and h 27 ie ma er treuma	Srey Chan/ Brothe	r	42	204 Ce	dar Tı	ee La	ne, Burto	nsvill	e, MD	20866			
permit. Pages 1 and 2 Department of Heelth Important: if Item 27 I any Injury or other tre	20a. Method of Disposition		20b. Place of	Disposition			July 3	-		r Town, State			
omit. Pages 1 er Separtment of Hee Important: if item in injury or other	1 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Othar (Specify,		Gate o						or Cnr	ing, MD			
Department Important Important Important Injur	21. Signatura of Funeral Sarvice Ligans		Jace C			ess of Facility		DIIV	er opr	Ing, In			
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):												
icete be executed physician and s the buriel-transit	X I if any leading to immediate												
ing physician e es the buria													
at the death cert d by the ettendin leteched for use Physician/W		d											
a de the e hed f	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	the underly	ing cause gi	ven in Part I.	23b.	Did tobacco u	uss contribu	te to the cause of deati			
ed by detect								1 Yes 2	ÍNo 3□1	Probably 4 Unkno			
The law requires that the death certificate be executed tate has been signed by the ettending physician and page 2 should be deteched for use as the burial-transit Completed by Physician/Medical Examila								23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?					
The law te hes sege 2								1□Yes 2	(No	1 ☐ Yes 2 ☐ No			
certificate rector, peg	25. Was cese referred to medical					26. Place	of Deeth (Check of	inly one)					
hysicie nis cert il direct	examiner?	Hospitai:	nt 2 ER/Ou	tpatient 3	DOA Ot	hor	sing Home 5 1		Other (Sr.	pecify)			
Attending Physician: or death. ector: Atter this certific by the funeral director, iffication: To Be (27. Manner of Deeth 1 Neturai 5 □ Pending	28e. Date of Injur (Month, Day		Time of njury	28c. Inju		28d. Desc	rlbe how injury					
To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, pege 2 Medical Certification: To Be Comp	2 Accident investigation 3 Sulcide 6 Could not be 4 Homicide determined	28e. Piace of Inju building, etc	ry - At home, fa . (Specify)				28f. Locati	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
he Hospita in 24 hours he Funerel pletely fille edical C	29a. Certifier (Check only one) Certifying Phy	raician: To the best of iner: On the basis of end menner sta	examination and	, death occu d/or investig	urred at the tigation, in my	ime, date and opinion, deet	place, and due to h occurred at the t	the cause(s)	and manner : place, and di	as stated. ue to the cause(s)			
Med the	29b. Signature and title of certifier				29c. Licen	se number		29d. Data	signed (Mo	nth, Day, Year)			
7-	· Chihi hay	yel M.	9.		MIN	4CMD		2 28	JULY	1999			
	30. Name and address of person who de 18/11, PR IN CE	ompleted ceuse of de	eath (item 23a) ((Type, Print)	Dr.	327,	Chier,	horse	12083	2			
State Registrar	31. Date filed (Month, Day, Year) JUL 2 9 19		r's Signature	G.	Sport	6							



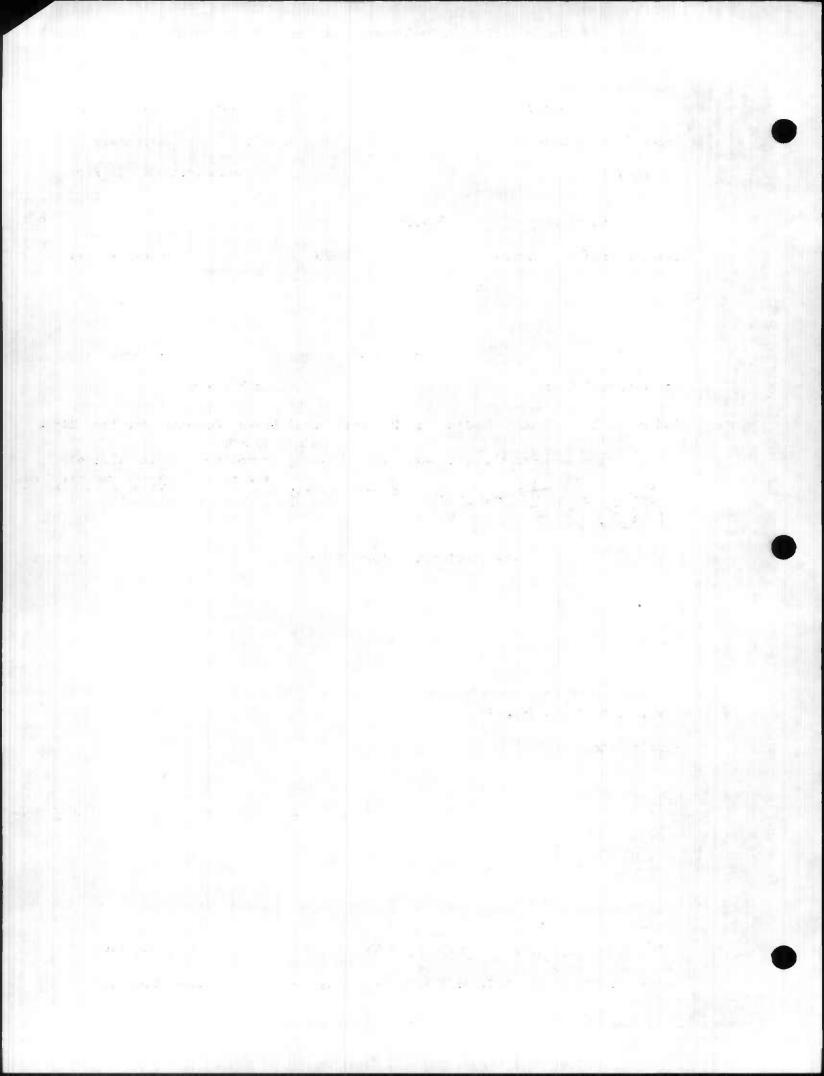
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedant'a Nema (First, Middla, Last) 2. Deta of Deeth 3. Time of Death Day Month **Physician** July 28, Bernadine E. Coates 1999 8:15 PM /Medical 4a Facility Nama (If not institution, give straat end number) 4b. City, Town, or Location of Daeth 4c. County of Death **Examiner** Manor Care Springhouse Bethesda Montgomery 5. Social Sacurity Number 6. Sax 7. Aga (In vrs. lest birthday) If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplace (Stata or Foreign **Funeral** 1□ M 2⊠ F Months Days Hours Illinois 88 December 10, 1910 Director 348-01-7161 Usual Rasidance of Decedant with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10e. Stete 10b. County **ehow** r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 11100 Hurdle Hill Drive 20854 United States Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whita, etc. after 1 Naver Marriad 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ò filed within 72 hours 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home other traumatic event. 18. Mothar's Nama (First, Middla, Meiden Sumeme) 17. Fether's Name (First, Middla, Last) Pages 1 and 2 should be fill ment of Health and Mental Hant: if Itam 27 is marked other traumatic even Be Anton Oberstetter Elizabeth Koepple 19b. Meiling Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) 11100 Hurdle Hill Drive, Potomac, Maryland 20854 Judith M. Coates/ Dtr.-in-law 20b. Pleca of Disposition (Nema of camatary, cramatory or other piece) August 7, 1999 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata
4 Donation 5 Bother (Spacify) Entomoment Resurrection Cemetery Mausoleum tment tant: If Peoria, Illinois 22. Nama and Addrass of Fecility Robert A. Pumphrey Funeral Home/ 21. Signatura of Funaral Sarvice Liferia Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00689 20814-3501 Bethesda, Maryland the disease, or complications that caused the leeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, art trillure. List only one cause on each line. Approximata Intarval Batwaen Onsat and Daath **Physician** /Medical immediata Causa (Finel a Arteriosclerotic Heart Disease diseese or condition resulting in death) 15 years Examiner Dua to (or as a consequence of): Examiner certificate be executed pue bunal-tran Sequentially list conditions, if any, laading to immediata causa. Enlar Undarlying Causa (Disaasa or Injury thet initiated evants resulting in daeth) Last Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical the Due to (or es e consequance of) USB BS lor the t Part II. Other significant conditions contributing to death but not rasulting in tha underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Type 2 signed b þ Records, 24b. Wara autopsy findings evallable prior to complation of cause of death? 24a. Was an autopsy Completed page 2 should peen Hypertension certificate has 1 Yas 28 No 1 □ Yas 2 □ No Division of Vital Physician: director, Be 25. Was casa rafarred to medicel 26. Plece of Daath (Check only ona) axaminar? Hospital: 1 | Inpatiant Other: 4 Nursing Home 5 Rasidance 6 Mother (Specify) Living Center 2 1 Yas 2⊠ No 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Daath 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred Mospital or Attending Pl 124 hours after death.
 Funeral Director: After th 5 Panding Invastigation Injury 1 Neturel 1 Yas 2 No 2 Accidant 3 Suicida 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) yd ni bellii 4 Homicida 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and place, and dua to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) To the I 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) elle D12121 July 29, 1999 10 30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print) George F. Sengstack, M. . 3929 Ferrara Drive, Wheaton, Maryland 20906-4709 31. Data filed (Month, Dev. Yaar) 32. Registrar's Signetura

State Registrar

JUL 3 0 1999

Dreva G. Sparks



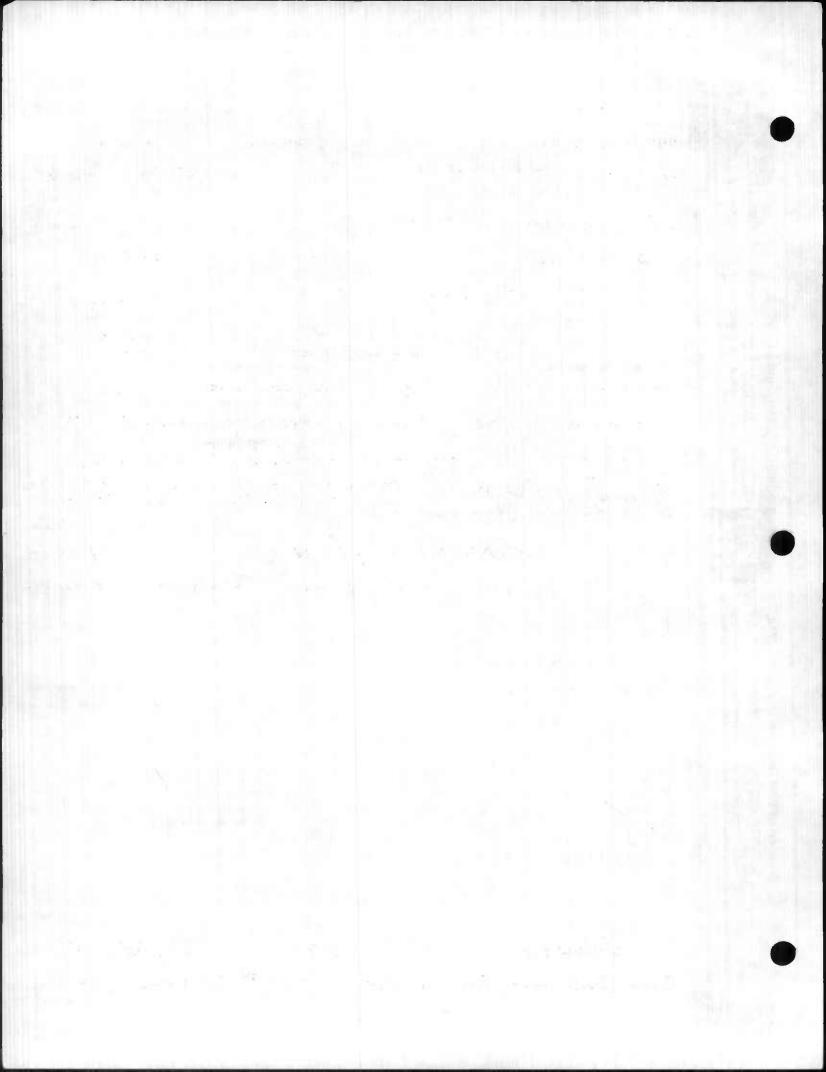
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** July 27, Robert A. Colilla 1999 8:10AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5010 Acacia Avenue Bethesda Montgomery Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Deys 1 X M 2 □ F Director September 29, 1934 New Jersey 142-26-1748 Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Manyland in and Mental Hyglene.
7 is marked other than "natural", or items 23s or 28s-f show traumatic event, fine Medical Examines must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 United States Funeral 5010 Acacia Avenue 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever In U.S. Armed Forces?

1 XI Yes 2 □ No If Yes, Give 1957— Yeer or Detes: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Merried 2 X Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0020 Specify: b 3 Widowed 4 Divorced White 1959 Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Computer Software Elementary/Secondary (0-12) College (1-4or 5+) 4 Developer Computer Analyst 17 Fether's Name (First Middle | ast) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 end 2 should be f ent of Health and Mental I nt: If item 27 is marked of Agnes Sinatra Ernest Colilla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 Acacia Avenue, Bethesda, Maryland 20814 item 2. Frances June Colilla / wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) July 29, 1999 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Si 22. Name and Address of Facility ervice Licenses M00831 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Mullence 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical andio Dulmonany Examine Examiner physician end the buriel-transit the deeth certificate be executed Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown lew requires that þ 24b. Were eutopsy findings available prior to should b 24a. Wes an autopsy performed? Completed completion of cause of death? s certificate has b director, pege 2 s 2 No 1 ☐ Yes 2 ☐ No director. or Attending Physician: Be 25. Wes case referred to medical examiner? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 2 ER/Outpetient 3 □ DOA Certification: To 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yes investigation 2 Accident Ofrector: 6 Could not be 3 Suicide 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 4 Homicide n 24 hour. The Funeral Direction Hospital Certifier (Check only one)

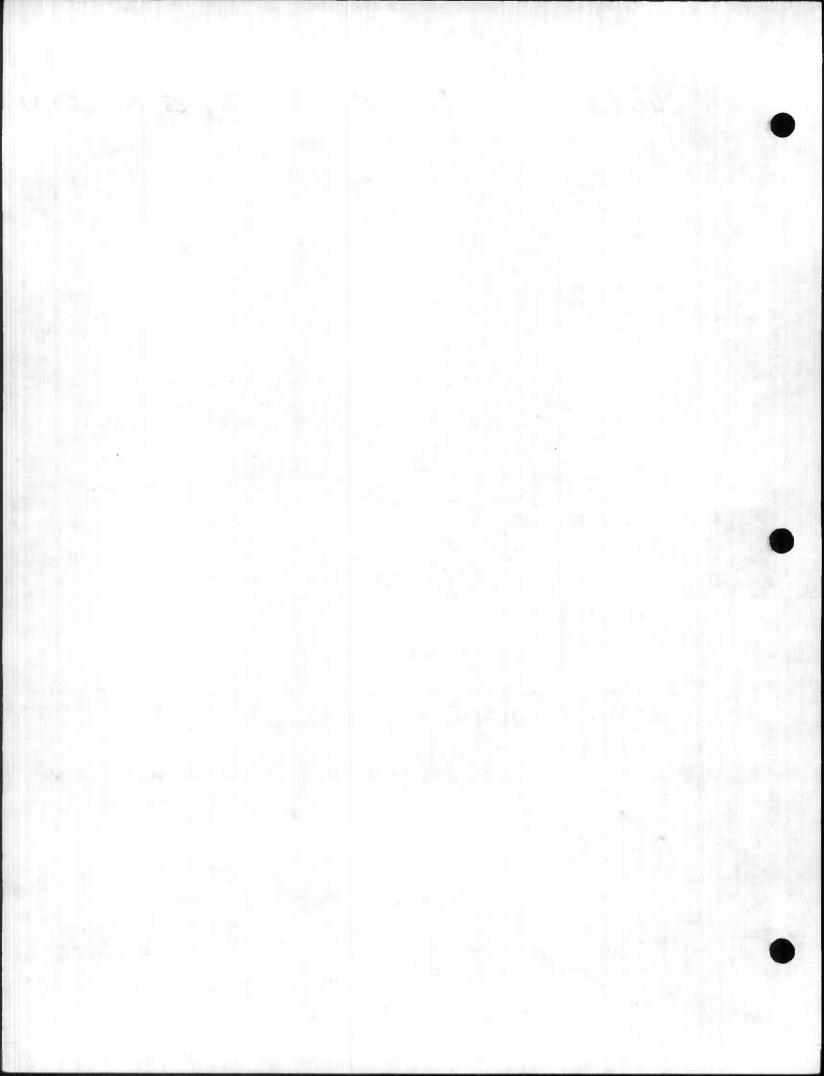
1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, and due to the cause(s) and manner as stated.

1 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edical within 24 ho To the Fune completely fi To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #300, KensingTon, MI WAllmank 1605 CONCONC 31. Date filed (Month, Day, Year) 32. Registrer's Signature JUL 30 1999 Registrar

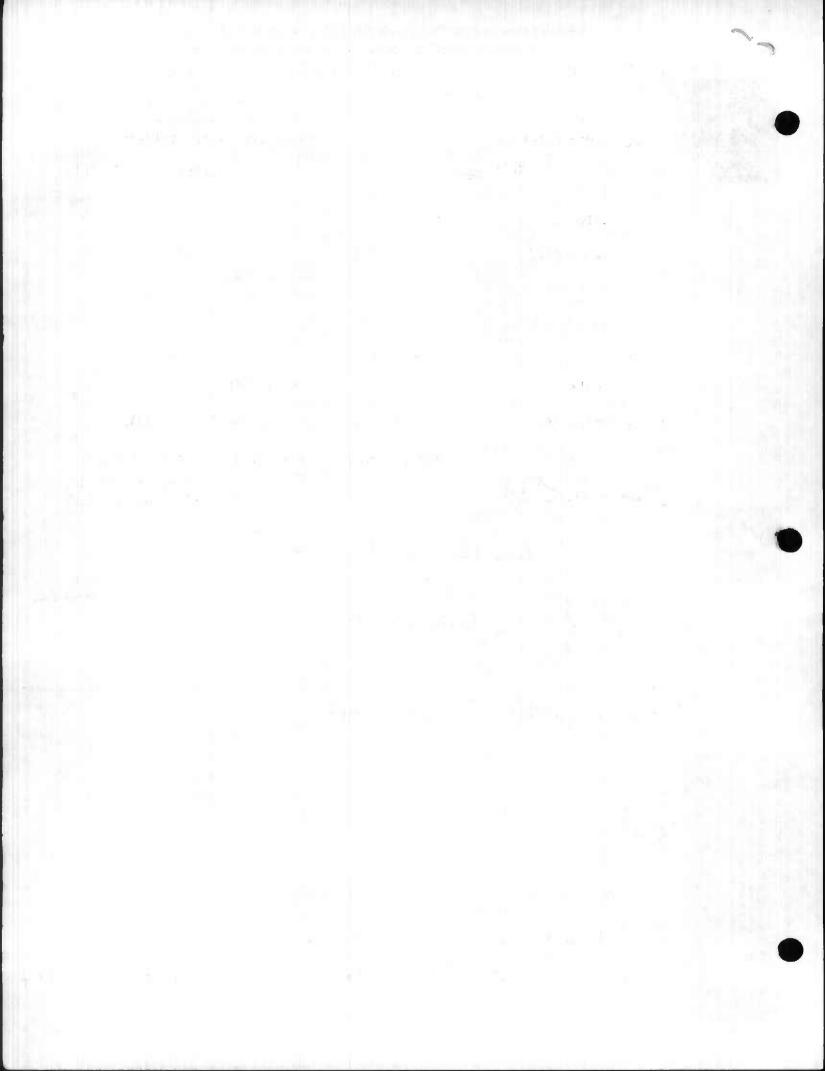


State of Maryland / Department of Health and Mental Hygiene 0 25101

			<i>'</i>	C	ertificate of	Death		Reg. No.	20101						
Phy	sician	1. Decedent's Nama (First, Middle, Las	10)	7//	100		2. Date of De	ath Day	3. Time of Death						
•	edical	CHALLE	((3//1	PIV	n	July	C3, 1	77 65 0 PM						
Exa	miner	4a Facility Name (If not institution, give	101 - 110	me		lb. Cay, Town, or Lo	cation of Death	4c. County	of Death						
74-2		5. Social Security Number 6. S		/	au) If Under 1 Year	If Under 24 Hrs.	0	170	O Richalana (State or Familia)						
Fune Direct		448-28-9278	D14 -D2	7 Yrs	Months Dave	Hours Min.	8. Date of Bir (Month, Da NOV • 4,	1931	Birthplace (State or Foreign Country) Oklahoma						
g		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or	Location				10d. Inside City Limits						
with the Marylar a or 28a-f show the notified at	ctor	Maryland Howard	La	urel					1 ☐ Yes 🖏 XNo						
Ith with the 23 and 24 and 24 and 25	al Directo	10e. Street and Number 10469 Gorman I	Road		10f. Zip Code 20723			10g. Citizen of W United							
hours after dea hursif, or items at Examiner ma	by Funeral	11. Marital Status 1 Nevar Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1XX as 2 No If Yas, Give Year or Datas: 1950—]		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yas 2XXIIo	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yas or No Rican, etc.)	14. Race Black Specify:	- American Indian, k, Whita, etc. White						
D-C	pete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. De	cedent's Usual Occup ive kind of work done	ation during most of worki	ina	16b. Kind of Bus							
within one the Man	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ 2	life	e. DO NOT use retired	1)			George's Co. Systems						
Maryjang 21213-0020 d 2 should be filed within 72 hours at the and Mental Physician. The marked other than "satural", or traumatic avent, the Medical Fram.	e B	17. Father's Nama (First, Middla, Last) Charlie				18. Mother's Name Bertha			9)						
Lyle hould d Mer marks	2	19a. Informant's Name/Relationship (1			ailing Address (Street										
Ma Pid 2 s Bith an 27 hs		Chris Richard Co.	***						land 21144						
Destrimore, semit. Pages 1 a Appartment of He important: if them inv Injury or other			Date 7/29/		City or Town, State ington, Virgin										
Mil. 1	#i	XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery 7/29/1999 Ari													
D SOL	8	Arlington National Cemetery 7/29/1999 Arlington National Cemetery 7/29													
		23a. Part1. Entar tha disease, or corbi	clications that causad the deat	h. Do not	enter the mode of dyir	g, such as cardiac of	or respiratory a	rrest,	Approximata Interval Between						
Physicia	an	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
/Medic	al	Immediate Cause (Final disaasa or condition rasulting In death) a. Reno Far Luve Due to (or as a consequence of): b. Due to (or as a consequence of): if any, laading to immediate cause Enter Underlying													
Examin															
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tificate be executed g physician and as the bunal-transit		Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or Injury	Due to (d	ras a con	sequence of):										
ficate be experience of physician	F	that initiated events resulting in death) Last	C. Due to (o	r as a cons	sequence of):										
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the death cert y the attending	cian						1		1						
the day	hysi	Part II. Other algnificant conditions co	ontributing to death but not ras	ulting in th	a underlying causa giv	en in Part I.	23b. Did tobacco use contribute to the cause of death								
s that	y P	consessive	MEGVI	the	Marc			29 110	On Flooring						
Physician: The law requires that the death certhicate has been signed by the attendiral director, page 2 should be detached for use	Completed by Physician/N			an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?										
he lay	ошо						10	Yes 2 No	1 ☐ Yas 2 No						
	Be	25. Was case referred to medical				26. Place of Deatl			7,110						
Physician: this certific	0	examiner?	Hospital: 1 Inpatient 2	ER/Outpa	tient 3 DOA Oth			dence 8 □Othe	er (Specify)						
er this	T:	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injur	e of 28c. Injur	y at		how Injury occurre							
Attending or death.	atio	1 Selatural 5 ☐ Panding investigation		ri ju	,	Yes 2 □ No									
or Attending after death. Director: After din by the fune	ertific	27. Manner of Death 27. Manner of Death 28. Date of Injury 28b. Time of Injury 28b. Injury 28c. Injury at Work? 28c. Injury a													
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 2 Medical Example 1	ysician; To the best of my kno niner: On the basis of examina and manner stated.	wledge, de tion and/or	eath occurred at the tir r investigation, in my o	ne, data and place, pinion, death occurr	and dua to the ed at tha tima,	cause(s) and mai data and place, a	nner as stated. and due to the cause(s)						
Fo the complex	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)						
20		> Yours Ko	winb		199	1617		Jula	23.1855						
9		30. Name and address of person who	on pleted causa of death (Item	23a) (Ty	pe, Print)	2/2 W-	111	. (-	und zinve						
	State	31. Date filed (Month, Day, Year)	32. Regigtrar's Signa	/T/(KOVS 14	450 100	(0/4	19,50	M C107/						
	istrar	JUL 27 19	399 Denem	_/	J. ppou	6									



A	mend #	7,7	/28/99,BMW,Montg.C	State of Maryla		artment ertificate			Mental Hy	/giene)	2	5102	
	Physic /Medi		Decedent's Name (First, Middle, Last DOROTHY	COMLE	Y.				2. Date of Do Month JULY 2	Day 25, 1999	Year	3. Time of Death 23:45	
-	Examir Funeral		4a. Facility Name (If not Institution, give Calvert County Ho 5. Social Security Number 6. So	spital	s. last birthday	If Under 1		Prince F If Under 24 Hrs Hours Min.	rederic	th 4c. Count k Calv	ert 9. Birth	place (State or Foreign	
	Director		224-48-3469 Usual Residence of Decedent 10a. State 10b. County	250	85 Yrs.				12/9/	1913	Vir	ginia	
	with the Merylen or 28s-1 show be notified	frector	Md Calvert 10e. Street and Number		usby	10f. Zip C	ode			10g. Citizan of		10d. inside City Limits 10€ Yes 2 No ntry?	
0000	or items 23	by Funeral Director	50 Appeal Lane #2 11. Marital Status 1 Never Married 2 Merried 303Wildowed 4 Divorced	2.15 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X No if Yes, Give Year or Dates:	U,S. 13.	2065 Was Deceder If Yes, specify	nt of H / Cuba	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No o Ricen, etc.)		ce - Ameri ack, White,		
	c = -	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucetion de completed) College (1-4or 5+)	16a. Dece (Give life.		Occupi done o retired	atlon during most of wor)	rking	16b. Kind of E		dustry	
=	Mentel Mentel arked o	To Be C	17. Father's Name (First, Middle, Last) George W. Hall	no Briefl				18. Mother's Nar	ZZens	, Maidan Suma	me)		
	the train		19a. informant's Name/Relationship (7. Carl C. Comley Jr 20a. Method of Disposition XXBuriai 2 Cremation 3 Cl	20b	7813 Place of Disp cemetery, cre	Worth osition (Name imatory or other	ing of erplace		exandria Date	, VA 22	315 - City or To	own, State	
Baltir	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	Sole	F	2. Name and . Arlingt	Addres	s of Facility Funeral	Ar	01 N. F	airfa	x Dr.	
	Physician /Medicai Examiner		23a. Part1. Enter the disease, or comp shock, or heart tailura. List only o immediate Causa (Final disease or condition resulting in death)	. Acut Re		Fa		g, such as cardied	or respiratory a	arrest,		Approximate intarval Batween Onset and Death	
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P.0	law requires that the death certific es been signed by the ettending p s 2 should be deteched for use as i	Completed by Physician/Medical	Part II. Other significant conditions co	1	esulting in the C	_		en in Part I.	1 🗆	obacco use contribute to the cause of defect 2 No 3 Probably 4 Unkran autopsy an autopsy tindin available prior to			
l Reco	inciant: The law require certificate has been si rector, page 2 should i	Complet								Yas 2 No	of	mpletion of ceuse death?	
of Vita	After this funeral di	To Be	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Data of Injury (Month, Day Year)	□ ER/Outpatie		Othe injury Work	4 LI Nursing H	lome 5 Ras			(v)	
5	to use mospinal or Attentioning within 24 hours effected at the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	2 110		Street and Num wn, State)	ber or Run	al Route Number,					
1	within 24 hours To the Funerel I	Medicai	29a. Certifier (Check only one) 29b. Signature and title of certifier	sician: To the best of my kr nar: On the basis of examin and manner stated.	my or	oinion, daath occu	, and due to the rred at tha tima,	data and place	, and dua to	o tha causa(s)			
	20		30. Nama and addrass of person who co	omplated cause of death //b	am 23a) /Tuna	D.	27	number		7 · Z	26.9°		
	Sta Registr		2 A+++ (L Y O 31. Date filed (Month, Day, Year) 1111 2.8 1999	USAF Registrar's Sign	P.O.	BOX	(1209	, WA	LDURG	- , N	1) 20604	



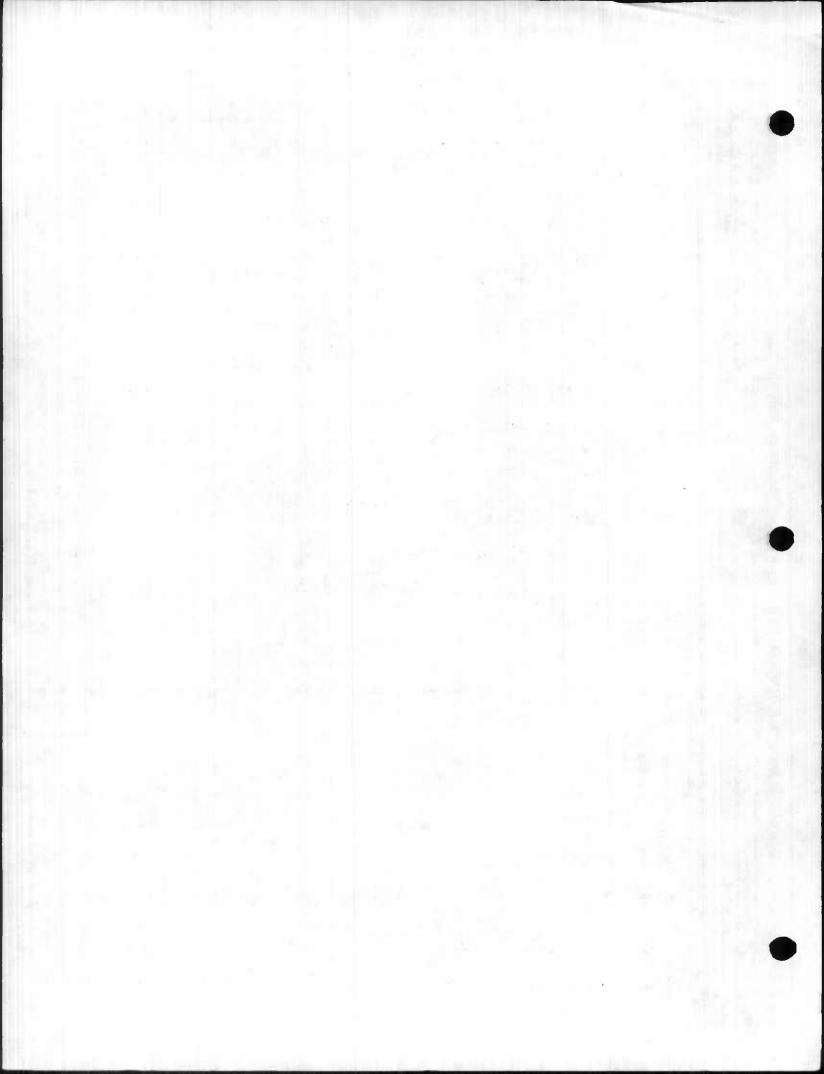
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Month Year **Physician** Crist 1999 10:50 PM Louise 26, E11a July /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick H Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2X F Vrs 79 Director 571-03-4735 October 27, 1919 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yas 2 No Director Maryland Frederick Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 'natural', or items 23s or the Medical Examiner must be 6131 Fieldcrest Drive 21701 United States Funeral 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. hours after 1 ☐ Yas 2 🛣 No If Yes, Give Year or Datas: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify. Àq 3 N Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i fied within 7. I Hygiene. other than "na Elemantary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Electrical permit. Pages 1 and 2 should be fiss Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic. 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Hattie Lee Spencer Samuel Jackson Hamilton 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6131 Fieldcrest Drive Frederick, Maryland 21701 Janet Eileen Crist/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) July 29, 1999 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue

Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue

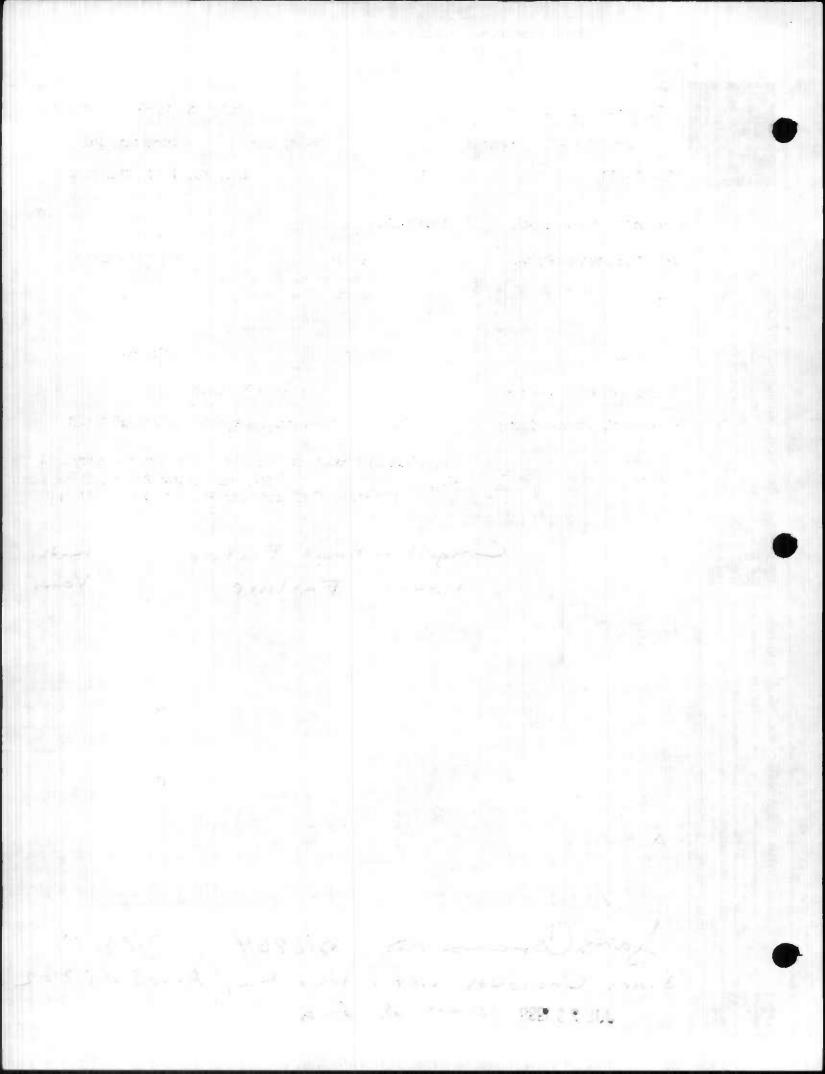
Bethesda Shock, or heart failure. List only one causa on each line. Parklawn Memorial Park Rockville, Maryland Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final ARDIOMYOPATHY SHTHON O disease or condition resulting in death) Examiner Examiner 10 YRS ISEASE HRTERY physician and the burial-transit Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that Initiated evants rasulting in death) Last Due to for as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 980 Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deed hes page 2 1 ☐ Yas 2 No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) To 1 Yes 2 No 1 Nonpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending after death. 2 Accident invastigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours a Hospitat edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only Within 2 To the 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47611 Nanard JULY 27, 1999 MI 2 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) FREDERICK MD 21702 204 MD 1475 TANEY AVE VEIL MARAVISIEKA 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State JUL **3 0** 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 25 1 11

							Cen	tificate	of De	eath		Re	g. No.	J Em	.0107			
	-		1. Decedent's Neme (First, Midd	le, Las	t)							Dete of Deeth	Dev	Yeer	3. Time of Death			
	Physiciar - /Medica		Clarence M.	Cr	rabbs							ilv 26		1001	8:16AM			
	Examine		4e Fecility Neme (If not institution						4b.	City, Tov	vn, or Locatio	n of Death	4c. County	of Deeth				
			Anne Arundel Me	edic	cal Center	r			An	napo	olis		Anne i	Arund	del			
	Funeral		5. Social Security Number	6. Se	X 7. Ag	ge (In yrs. lest		If Under 1 Y Months D		Under 2 Hours	Min. 8. C	eta of Birth Month, Dey.	Year)	9. Birthp	olece (State or Foreign			
н	Director		319-30-8339	13	ZW ZU F	88	8 Yrs.					1. 18,		Colo	orado			
	pur *	-	Usual Rasidence of Dacedant 10e. Stete 10b. County	,		10c. City, T	own or Loc	ation						1	Od. Inside City Limits			
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	tha Mary 28a-fah	Director	Maryland Anne 2	Arur	ndel	Anna	apoli:	10f. Zip Co	de			10	g. Citizen of V	What Cour	210v2			
	with with											- "						
	72 hours after death with the Maryland naturel, or items 23e or 28e-f show Jeal Examiner must be norfled at	runeral	2997 Southhave	n Di	12. Wes Decedent	Ever in U.S.	13 W	2140		enlo Orio	in? (Specify)	Yes or No-	United		ates can Indian.			
	tar dea		1 Never Merried 2 Mar	ried	Armed Forces? 1 ☐ Yes 2 🔼	No					in? (Specify ' Puerto Ricar	n, etc.)		k, Whita,				
Maryland 21215-0020	ars aff	2	3 ☑ Widowed 4 □ Divorced		If Yes, Give Yeer or Detes:		1	□Yes 2🛚	No S	Specify:			Specify	whit	te			
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la I		0	George Frankli	n C	rabbs					Amar	nda Wh	itmore						
an	sh and		19e. Informent's Name/Raletion:				19b. Meiling	Address (Si	treet and	Numbe	r or Rural Ro	uta Number,	City or Town,	Stata, Zip	Coda)			
1 -	Haaith of Haaith		William C. Cra	obs	(son)					Dr.	. Annar		Maryl					
ore	ges fan it of Haall if Nem 2 or other	-	20a. Method of Disposition 1 □ Buriai 2 🔀 Cremetion	2 🗆	Bamoval from State	20b. Pleci cem	a of Dispos etery, crem	ition (Neme of etory or other	of r plece)		Da	ate 2	Oc. Location -	City or To	own, Stete			
altimore,	@ E # >		4 Donetion 5 Other (S				Linco	ln Cre	mato	ry :	7/29/99	9 E	rentwo	od, N	Maryland			
alt	permit. Page: Department of Important: If I any Injury or phes.		21. Signature of Funeral Service	Licens	100	A	22.	Name end A	ddress	of Fecility	John I	M. Tay	lor Fu	nera]	l Home, Inc			
m	89 6 8 8		22. Name end Address of Fecility John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 2140 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate interval Between															
			23a. Part1. Entar the diseese, o	r comp	cations thet caused	d the deeth. I	Do not ente	r the mode of	f dylng,	such es	cardiec or res	piretory erre	st,	1	Approximete			
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м	/Medical		Immediate Cause (Finel disease or condition		Cu	mae	stiv	e He	2014	+ 1	Fail	lux-		1	months			
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State of Maryland / Department of Health and Mental Hygiene 9 9 25

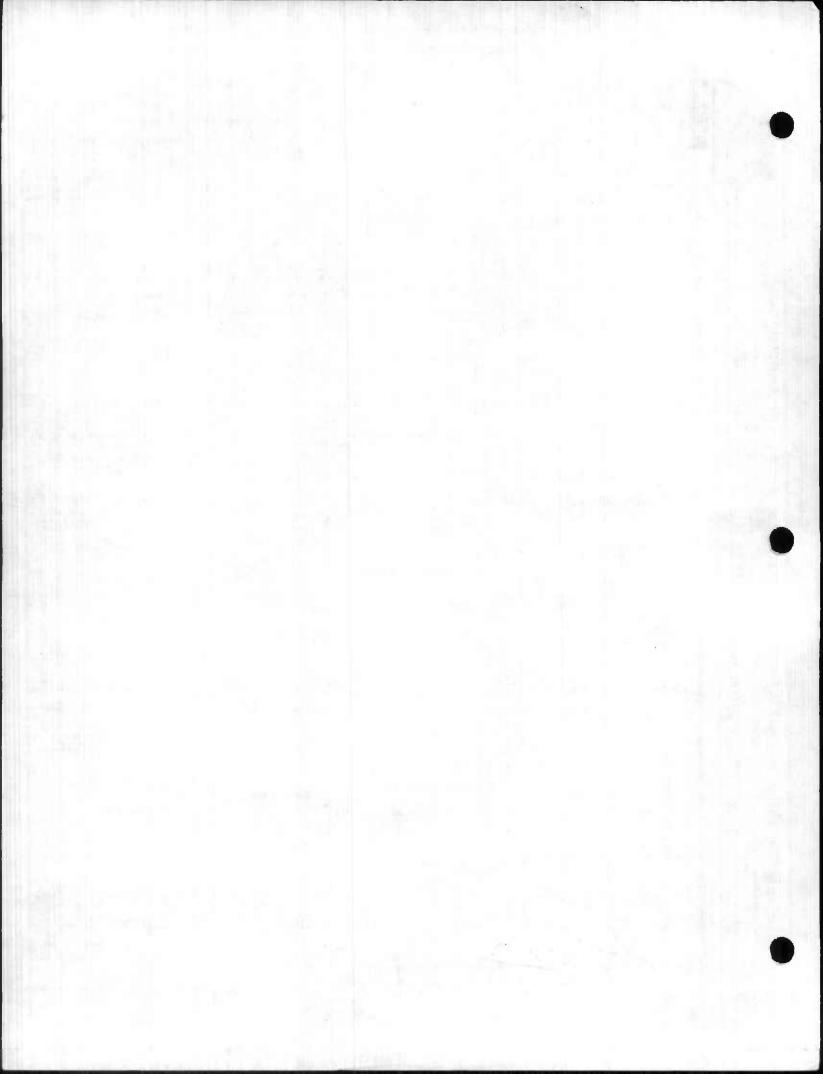
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 22 1999 7:15 pm ELLEN CAREY JULY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not Institution, give street and number) Examiner A NNAPOLIS NURSING & REHAB. CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 □ M 2 ₽ F Yrs. Director 99 578-05-3818 MAY 28 1900 D.C. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 25s-f shot traumetic event, the Medical Examinar must be notified at MARYLAND ANNE ARUN EL 1 Nes 2 No ANNAPOLIS Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 280 T HILL TOP LANE 21403 US Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after next of Health and Mental Hygiene. Inti if Item 27 is marked other than "natural", or ite 1 □ Never Married 2 □ Merried Maryland 21215-0020 If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: þ 3 DWidowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11th ELEVATOR OPERATOR FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) UNOBTAINABLE EDITH CREDITT 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21403 19a. informant's Name/Relationship (Type, Print) 201 ANNAPOLIS, MD. JULIA PHILLIPS (COUSIN) 940 BAY FOREST CT. APT. Department of Health Important: If Item 27 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ANNAPOLIS MEM. GARDENS 7/28/99 ANNAPOLIS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licensee 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. Larry 23a. Part1. Enter the Jisease, or compile ations that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or, es e consequence of): Examiner 11 physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) P.O. Box 68760 Physician/Medical Due to (or as e consequence of): 0 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by I 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed 22 No 1 Yes 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D 1 Carifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 281999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Grace Geneva July 22, 1999 11:45 A.M. Davis /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11505 Montgomery Road Beltsville Prince George's Co. 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□ M 20 F 89 Yrs. 214-22-3411 August 3,1909 Maryland Director Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exactions must be notified at Maryland Prince George's Beltsville 1 No Yes 2 No Director 10g. Citizen of What Country? United States 10a. Street and Number 10f. Zio Code death with 11505 Montgomery Road 20705 of America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked oths any Injury or other traumatic avent, blice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Howard Clifton Wilson Bessie Alice Mosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Terry/ Daughter 11505 Montgomery Road, Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) Cemeter y July 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Immanuel Union Church 4 ☐ Donation 5 ☐ Other (Specify) 123, 1999 Cheswold, Delaware 21. Signature of Funeral Service Licensee #M00690 22. Name and Address of Facility Torbert Funeral Chapel 61 South Bradford Street, Dover, Delaware 19904 austr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervai Between Onset and Death **Physician** /Medical Immediata Causa (Finai 7 years Alzheimers Disease disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lasf Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): 980 P.O. been signed by the a should be detached f Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension Records, þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1□ Yes 2☐No 1 ☐ Yes 2 ☐ No certificate of Vital Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 \$\vec{\times}\$ Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 28c. Injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of Division After 1 KMatural 5 Pending 1 Yes 2 No death. investigation 2 Accident or Attendation of the death of the office of 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral C Hospital 29a. Certifier Medical 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 \$ 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) 2 July 22, 1999 D25430 30. Name and address of person mad cause of death (Item 23a) (Type, Print) John Margolis, M.D. 13952 Baltimore Avenue, Laurel, Maryland 20707 31. Date filed (Month, Day Year) 1999 32. Registrar's Signature State bouls Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Mercedes Garcia De Angel July 25,1999 11:30 am /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3115 University Blvd., West #6 Kensington Montgomery If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F Yrs 229-47-5737 69 Sep. 15,1929 Director El Salvador Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland | Montgomery Kensington 10e Streat and Number 10f. Zip Code 10g. Citizen of What Country? 3115 University Blvd., West #6 20895 death Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours effer and Mental Hygiene.
marked other than "natural", or has 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Merried Specify: El Salvadori Specify: White 1 No 2 No à 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 end 2 should be file.
Department of Health and Mental Hyg. Important: if flam 27 is marked any injury or other ton.
DAGE. 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose Blanco 2 Rosa E. Garcia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Dinorah E. Rodriguez/Daughter 3115 University Blvd., West, #6, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State July 29 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1999 Silver Spring, MD 22. Name and Address of Facility. Francis J. Collins Funeral Home, Inc. 21. Signeture of Funeral Service License 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. river 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . Septicemia Examiner Due to (or as a consequence of) Examiner b. Chronic Renal Failure the death certificate be asscuted physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Congestive Heart Failure Physician/Medical Due to (or es a consequence of): by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Ď 24a, Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed The law **Dege 2** 1 Yes 20 No Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | EP/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 1 Tyes 2 X No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding 12 Netural death. 1 ☐ Yes 2 ☐ No investigation n 24 hours after death we Funeral Director: A pletely lilled in by the f 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) 4 Homicide 6 Hospital 29a. Certifier edicai 1🔯 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely ! (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 050678

State Registrar

3

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

Division of Vital

DHMH 16 Rev 6/95

Rajeev Batra M.D.

31. Date filed (Month, Day, Year)

ORIGINAL

10801 Lockwood Drive, Suite 325 Silver Spring, MD 20901

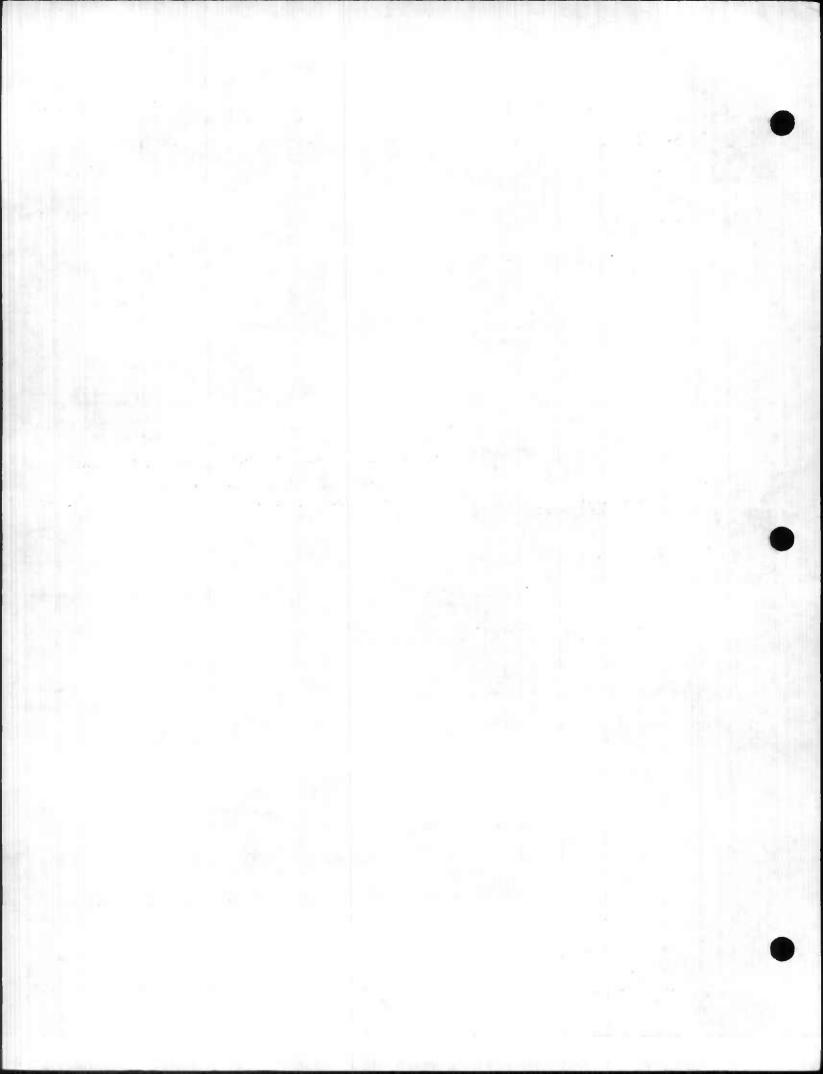
M.D

32. Registrar's Signature

Museum

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

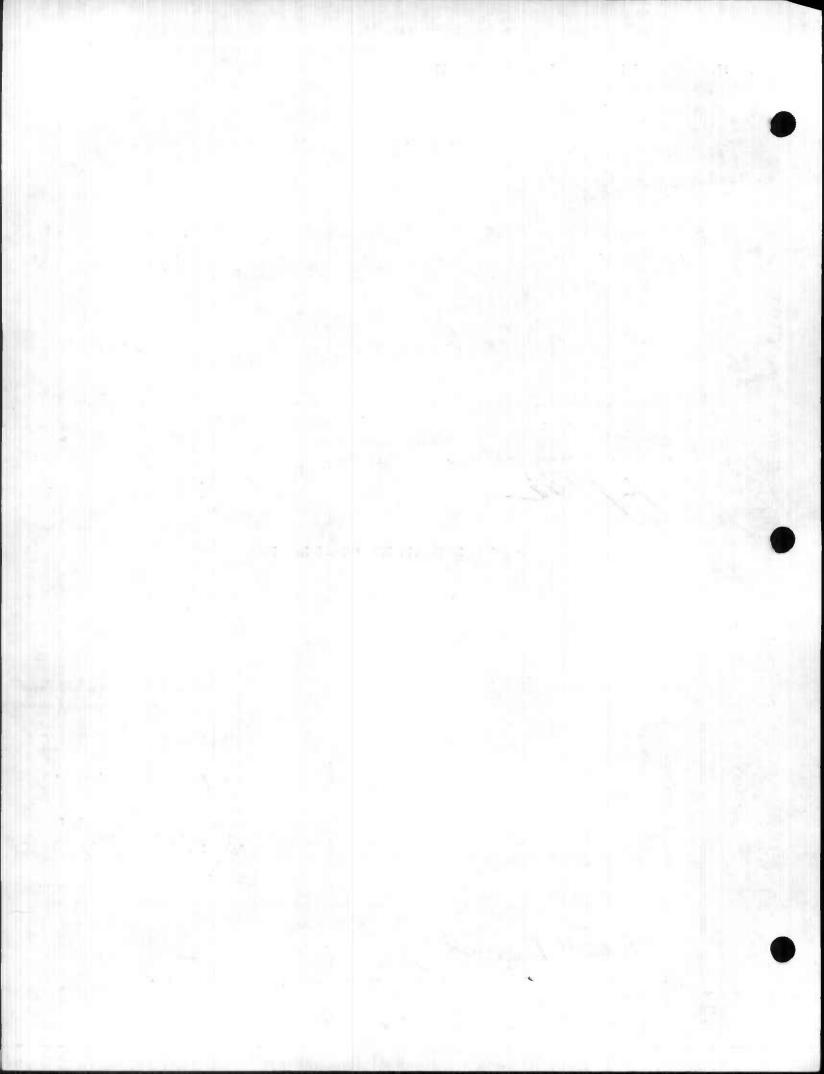
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State of Maryland / Department of Health and Mental Hygiene

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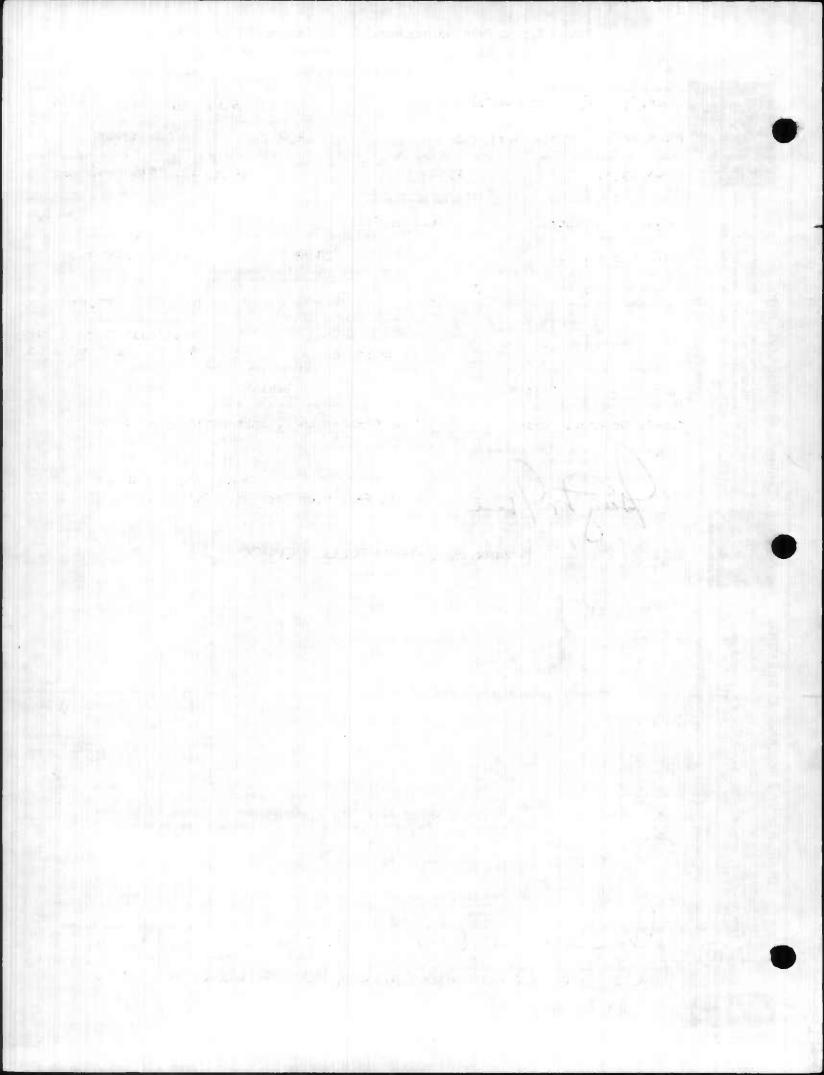
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S should and M and M and M and M T	19a. Informant's Neme/Relationship (7	Type, Print)	19b.	Mailing Ad	dress (Street				r, City or Town,	State, Zic	Code)			
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or all the	1 ☐ Burial 2 ☐ Cremetion 3 ☐	-27-99 Beltsville, Maryland												
Itimo chant in chant if	4 Donation 5 Other (Specify					lle,	Maryland							
Baltimore permit. Pages 11 Department of Ho Important if Item any Injury or oth BRS.	21. Signature of Funeral Service 12. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland													
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Division To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:		yalcian: To the best of r liner: On the basis of ex and menner state	xaminetion and											
o the omple	29b. Signature and title of certifier		29d. Date signe	d (Month.	Day, Year)									
10	DTh. 1 11													
	1 / mount	the same				C.M.E.	•		July	21,	1999			
	30. Name and address of person who of THEONORE M. KIN					Balti	imore,	Maryl	and 212	201				
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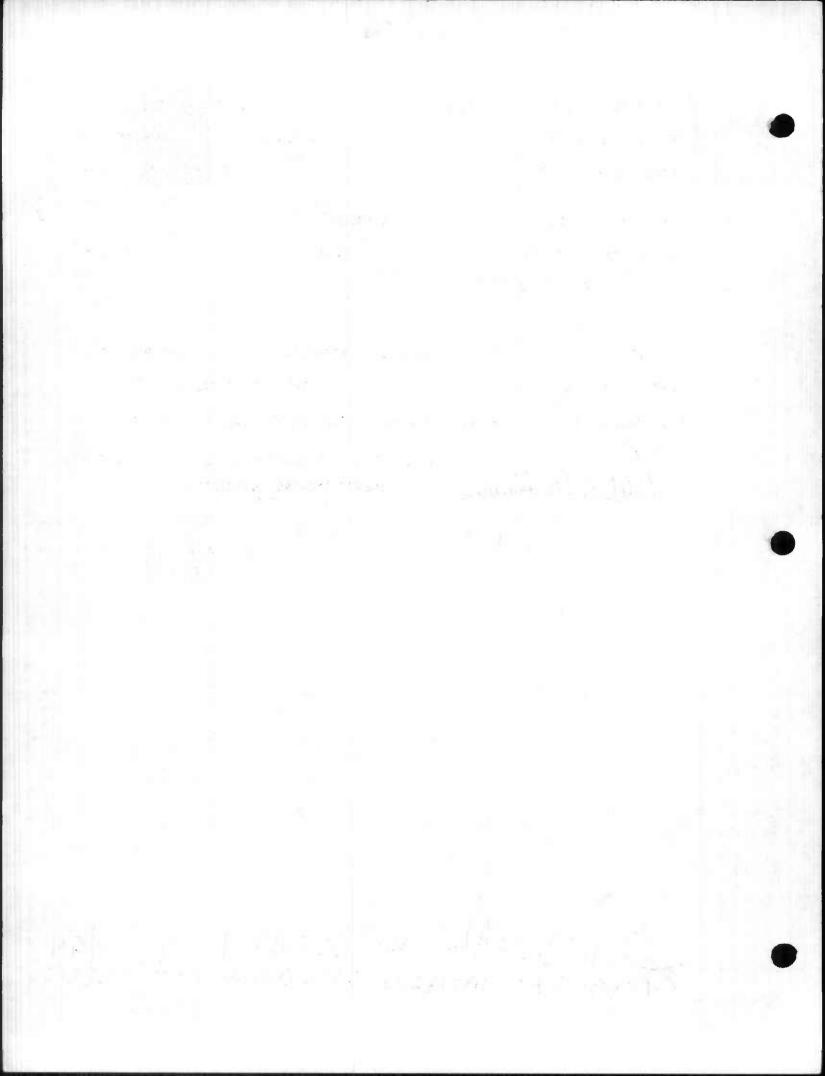
State of Maryland / Department of Health and Mental Hygiene 9 9 25 1 0 9

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Physician /Medical	1. Decedent's Name (First, Middle, La: RALPH E	DRINNON				2. Data of D Month	Dey	Year 999	3. Time of Death	
Examiner	4a Facility Nama (If not institution, given MONTGOMEN) GENER				4b. City, Town	, or Location of Dea	MONT		7	
Funeral Director		7. Age (In yrs	: last birthday, Yrs.	Months Day		Min (Month, L	irth Day, Year) 23, 1936	9. Birthpl Count Teni	ace (State or Foreign try) nessee	
death with the Merylend ms 23s or 28s-f show mans be notified at meral Director	Usual Rasidance of Decedent 10a. Stata 10b. County Maryland Montgome		Burtons					10	0d. Inside City Limits 1 ☐ Yas 2 ☐ No	
h with the 13a or 28	10e. Street end Number 16100 Oursler Road	d		10f. Zip Code	20866		10g. Citizan of V United			
_ 5 2 5	11. Maritel Status 1 Naver Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar in to Armed Forcas? 1 ☐ Yas 2 ② No If Yas, Giva Year or Datas:	U,S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N	ban, Maxicen, I	n? (Specify Yas or N Puarto Rican, atc.)		e - America ck, White, a		
15-0 n 72 hc	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12)	ducation de completed) Collage (1-4or 5+)	(Give	edent's Usual Occ a kind of work don DO NOT usa rati	a during most o	f working		al Cap	pital Park	
be filed within tel Hygiene. d other than svent, the Me Compi	7 17. Fether's Nama (First, Middle, Last)	SCHOOL SCHOOL	N	Mechanic	18. Mother's	s Nama (First, Middl			ommission	
Maryland d 2 should be file th and Mentel Hy 7 Is merked othe traumatic svent	Rex D	rinnon			Веч	ılah	Seal	Ls		
ary s me	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Addrass (Stre	et and Number	d Number or Rural Route Number, City or Town, State, Zip Code)				
M and 2 and	Bonnie Drinnon,				er Road, Burtonsville, MD 20866 Data 20c. Location - City or Town, State					
Baltimore, Maryland 212 permit. Peges 1 and 2 should be filed within Department of Heath and Mentel Hygiene. Important: If Item 27 is marked other than any injury or other traumatic svent, Ins. Mance. To Be Comp	20e. Method of Diposition 1 N Bur 2 1 Cremetion 3 C 4 Department 5 Dotter (Specific		7/24/99	20c. Location -						
Balt Departi Importe any inje	21. Signature of Juneral Service Licer		2	2. Nama and Ado	ress of Fecility		Funeral	Home		
Physician /Medical Examiner	23a. Part 1 Chlor the discuss, or com- shoot, or heart fayors. List only Immediate Ceuse (Finel disease or condition	on cause on each line.					arrest,		Approximate Interval Batween Onsat end Death	
A Desired Land	resulting In death)		(or es a conse							
68760, ficate be executed physicien end as the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury	Dua to	(or as a consa	quance of):						
× = E o Z		Due to ((or es a consa	quence of):						
death ce attend ad for us	Pert II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying ceusa	given in Pert i.	23b. DI	d tobacco uae co	ntributs to	the cause of death?	
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cord requir							es an autopsy formed?	ava	ere autopsy findings alleble prior to mpletion of ceuse death?	
The law rate hes page 2						10	Yes 2 10	1 🗆	Yes 200	
f Vital I yelclan: The s certificate director, pag	25. Was cesa rafarrad to madical examinar?					of Death (Check only	v ona)			
- K 50 D	1 Yas 2□ No		PF/Outpatie	IN SLI DOA		ing Homa 5□ Re			y)	
E go age	27. Manner of Death 1. Staturel 5 Pending 2 Accident investigation		28b. Tima o Injury		juryat /ork? □Yes 2□No		e how Injury occur	red		
Divis	3 Sulcide 6 Could not b 4 Homicide detarmined	9 28a. Place of Injury - At building, atc. (Spec		treet, factory, offic	8		28f. Location (Street end Number or Rural Route Number, City or Town, State)			
Division C To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:		yalclan: To the best of my kn niner: On the basis of examin and mannar stated.								
100	29b. Signature and title of certifier	no. (or	NB)		nsa number 5236		29d. Data signe			
4(10)	30. Nema end addrass of person who completed causa of deeth (Item 23e) (Type, Print). CARL Z. WALGOUS, WO. 1175 ROCKVIUG PILE, POCKVIUG, MO 10852									
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	loan	/. /					



State of Maryland / Department of Health and Mental Hygiene \(\)

						Ce	rtificate	of	Death		R	leg. No.	6.0		
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~			GENESIS ELDERCA	RE					LA PL	ATA		CHAR	LES		
	Funeral		5. Sociel Security Number	6. Sax 7.	Age (In yrs. las	t birthday)	If Undar 1 Months	Yeer		24 Hrs. Min.	8. Data of Birth (Month, Day	Vear	9. Birthp	laca (Stat	ta or Foreign
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	ehov d at	_	10a. Stete 10b. County		10c. City,	lown or Lo	ocation						11		City Limits
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	\$ 0.0 S	- In	10e. Street and Number				10f. Zip C				1	0g. Citizan of 1	What Coun	try?	
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	temes der	Funeral Director	11. Marital Status	12. Was Deceder Armed Forca	s?	13.	Was Deceda If Yas, specif	nt of y Cub	Hispanic Or pan, Maxica	igin? (Spi n, Puarto	ecify Yes or No- Rican, atc.)		ck, White,		
20	ges 1 and 2 should be filed within 72 hours after deeth with the Meryland tof Heelth and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Examine	by F	1 Navar Married 2 Marr	If Yas, Giva	⊐№ 1960	-	1 ☐ Yes 2	No	Specify:			Specif	/: t.111	TTT	
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0	filed with Hygiene. other than		17. Father's Neme (First, Middle,			COMP	JIEK II	نابات			e (First, Middle, I			10113	
Maryland	Mental Mental arked o	o Be	CLYDE R. ECKLER								. CADDIO		,		
2	should and Men marke umaric	J.	19e. Informant's Name/Relations			19h Maili	ng Address /	Stree			al Routa Number		State Zin	Code	
S	end 2 sho selth end I n 27 is ma		MRS. CAROLYN L.		WIFE						WALDORF	-			
a)	of Heelth of Heelth Item 27 I		20e. Method of Disposition	20-112211	20b. Plac	e of Dispo	osition (Nama	of		1		20c. Location		-	
Baltimore,	Pages nent of nt: If its rry or o		1 Buria 2 Cramation		ta		matory or oth		,	MC O	7-31-99				
量	permit. Page Department of Important: If any Injury or once.		4 Donation 5 Other (S)	- 0	IKIN		2. Nama and				7-31-99	WALDO	KF, FI	AKIL	AND
Ba	permit. Page Department of Important: If any Injury or once.		MGB Author of Fugeral Sergice	Six gun	~	TH	E HUN	ΓT	FUNER	ÄL H	OME, INC	J.			
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	Physician /Medical	ш	Immediata Causa (Final	1 1/10	Ann	Ha	the	1	oro)	1 A 10	2000	10	CND.	4	(14)
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	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/	Part II. Other afgnificant condition	ne contributing to death	hut not resulti	ng in the u	indadvlna cai	ICO CI	iven in Part		23h Did to	obacco use co	atribute to	the caus	es of death?
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State of Maryland / Department of Health and Mental Hygiene 9 9 25

					Certificat	e of	Death		leg. No.	(no	OTT	
	20	1. Decedant's Name (First, Middla, La	sf)					2. Date of Dea		Vaar	3. Time of Death	
	Physician / /Medical	Sarah E.	Eife					July 2	28, Day 1999) ' a a i	9:35 a.m.	
	Examiner	4a Facility Nema (If not institution, giv. Chesapeake Hospid					4b. City, Town Linthic	, or Location of Deeth CUM	4c. County Anne		del	
	Funeral Director	5. Social Security Number 162–10–9623 1	ax 7. Age	(In yrs. last birt	hday) If Undar Months			Min. 8. Data of Birti	1914	9. Birthp Coun Penn	place (Stata or Foraign	
	8 .	Usuel Residence of Dacedant 10a. State 10b. County		10c. City, Town	or Location					1	Od. Insida Ctty Limits	
	with the Maryland t or 28a-f show be notified at Director	MD. Anne Ar	undel	Arnold							1 ☐ Yas 2 🕅 No	
	1 5 A	10e. Street end Number 336 Long Meadow	Way		10f. Zip	210	12		United			
0000	ours after death vines. 23s Examiner must by Furneral	11. Maritel Status 1 □ Nevar Married 2 □ Merrlad 3 ☑ Widowed 4 □ Divorced	12. Was Dacedent E Armad Forces? 1 Yas 2 N If Yas, Giva Yeer or Dates:		13. Was Deced If Yes, spec			n? (Specify Yes or No- Puarto Ricen, atc.)		e - Amaric ck, Whita, v:Whit		
50	72 hg mattur dical	15. Decedant's Ed (Specify only highast gra	lucation da completed)	16a.	Decedent's Usua (Giva kind of wo lifa. DO NOT us	ai Occu	pation during most o	f working	16b. Kind of B	usinass/Inc	dustry	
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land	lid be file lential Hy kad othe ic event. O Be C	17. Fathar's Nama (First, Middla, Last) James Wholey						Name (First, Middla, Maidan Sumama) Hobon				
Maryland 21215-0020	aith and N 27 is mar r traumat	19a. Informant's Name/Relationship (Walter Eife (so						or Aural Aouta Numbe tmont, New				
Baltimore	Page 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20e. Mathod of Disposition 12D Buriai 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specify		cemetar	Disposition (Nar y, cramatory or o seph's (othar pla		Data 8-2-99	20c. Location -		own, Stata	
Balt	Departit Departit Importa any inji	21. Signature of European Service Licen	Sea					John M. Tag cester St.			MD. 21401	
		23e. Part1. Entar the disease, or com- shock, or haart failura. List only	plications that caused	the deeth. Do n	not enter the mod	da of dy	ing, such es ca	ardiac or respiratory ar	rast,		Approximata Intervel Batween	
۱	Physician /Medical Examiner	Immediate Cause (Final diseasa or condition rasulting in death)	. Re	ctal	Co	an				1	8 months	
	<u> </u>			Dua to (or as a c	consaquance of):							
o,	physician and s the buriet-transit and Cal Examiner	Sequantially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants	b	Due to (or as a c	consequence of):	:				1		
x 68760,	M Ban	Cause (Disease or Injury that initiated evants resulting In death) Lest	d	Dua to (or as a c	onsequance of):							
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Records,	The law requires that the death ce sate has been signed by the attend page 2 should be detached for us.				1			24a. Was perfo	an autopsy med?	av	are autopsy findings vallable prior to ompletion of ceusa death?	
	cate has by page 2 s							101	as 2 No		□Yas 2□No	
of Vital	iclan: certific rector	25. Was cesa rafarrad to medicel axaminar?	Hospitai:			O	hor	f Death (Check only o	1/			
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	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. Medical Certification: To Be Com			axamination and				place, and due to the occurred at the tima,				
	Nithin Fo the Compl	29b. Signetyra and titia of cartifier			296	c. Lican	se number		29d. Date signe			
	- 3-0	Jeanne (Verse	, m1)		DS	5283	0 :	JUY.	28,1	999	
		30. Name and address of person who of Segnine We	complated causa of de	ath (Item 23a) (Type, Print) 1365 FG	at	Rd	Annay	slis u	10	10415	
П	State	31. Data filed (Month, Day, Year)	32 Registra	r's Signatura	2.	,			,			

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MEND	ITEMS:	#23	PART	Ι,	ΙI	27	PER	MEO	G774	8-11-99	WR	· Certificate	of Dea	th		

Physician
/Medical
Evaminer

Funeral Director

the Maryland 28e-f must be e fied within 72 hours after d if Hygiene. other than "natural", or flerr vent, the Medical Examiner.

permit. Pages 1 and 2 should be file.
Department of Health and Montal Hy
Important: If Item 27 is marked othe
any Injury or other traumatic event,
2006s.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examine sloian and burial-transit ng physician Physician/Medical 080 signed by the a þ should Completed page 2 hes funeral director. Be edical Certification: To this After within 24 hours after death. To the Funeral Director: Al the ! filled in by

The lew requires that the death certificate be assecuted

Box 68760,

P.O.

Records,

of Vital

Division

or Attending Physician:

Hospital

To the

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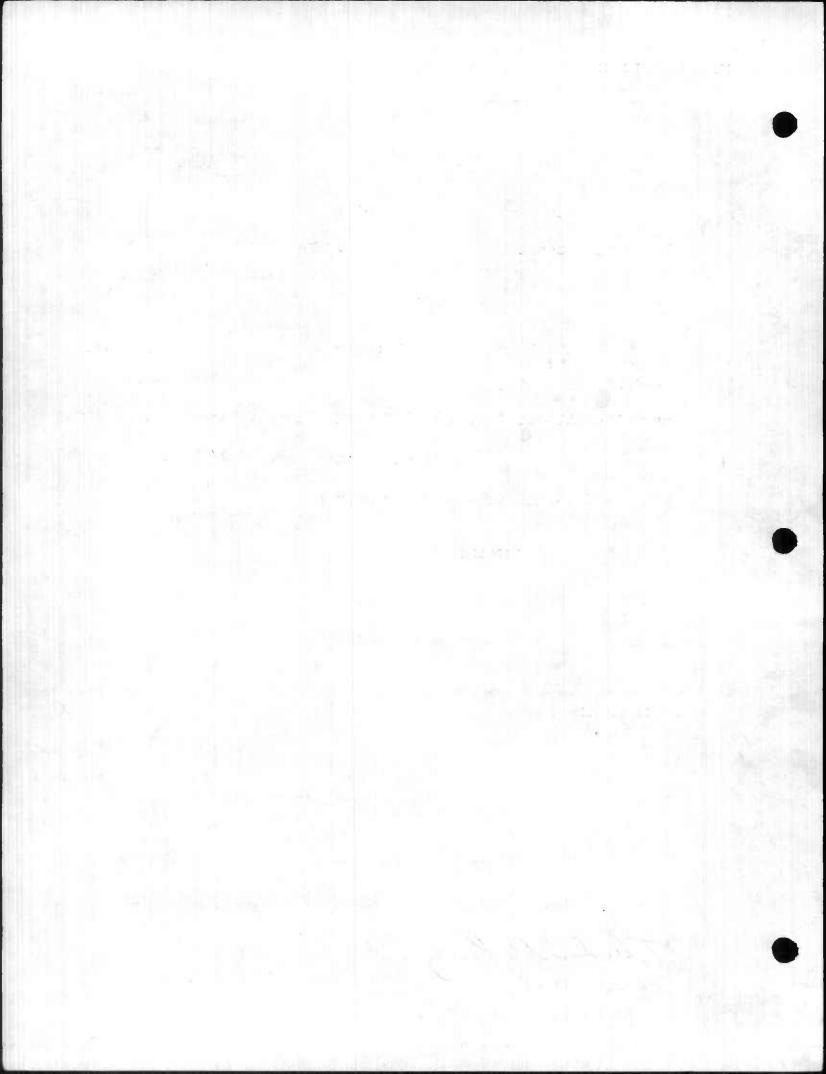
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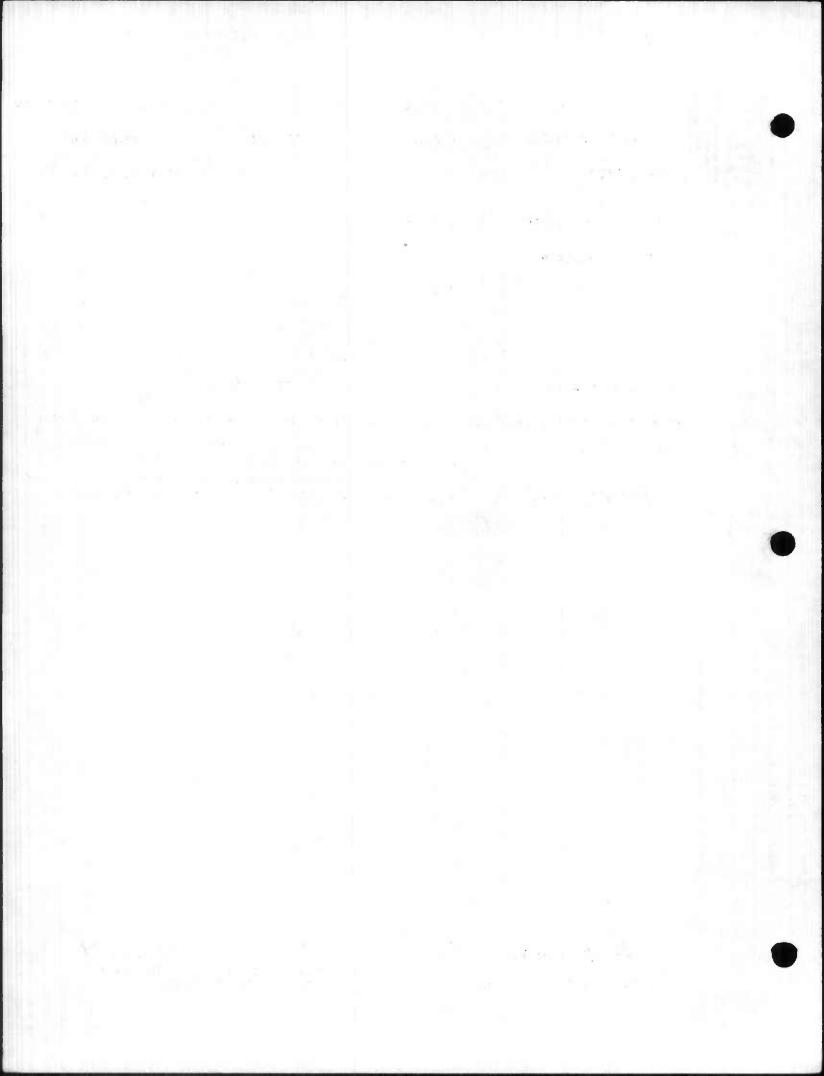
Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey Month 1445 PM ALAN Μ. ELLIOTT 20, JULY 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Dey. Year) Oct. 17, 1947 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 12 M 2□ F Wash. DC 51 219-46-6572 **Usual Residence of Decedent** 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Rockville MD Montgomery 1 Yes 2 □ No Directo 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 North Street 20850 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Merried 1X Yes 2 □ No If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2 ☐ No Specify: à 3 ☐ Widowed 4 ☐ Divorced 68-71 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 Yr Construction Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ella Young Benjamin F. Elliott, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 North Street, Rockville, MD 20850 Mary Ella Elliott (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete ** Surial 2 Cremetion 3 Removel from State Arlington Nat'l Cem. 7/28/99 Ft. Myer, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeret Service Liceru 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) FATTY LIVER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC ALCOHOLISM 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 25. Was case referred to medice! axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XYes 2□ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 28l. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only onel 29d. Date signed (Month, Day, Year) JULY 21, 1999 29c. License number 29b. Signature and title of certifie O.C.M.E. ceople)(Type, Print) 111 Penn Street, Baltimore, Maryland 21201 30. Name and address of person who completed cause of death (light (HEDDORE Mike 31. Date filed (Month, Day, Year) 22. Registrar's Signature

souls



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	Physic /Medi		Decedent's Neme (First, Middle, La HARE		ETT	rer -			2. Dete of De Month		999	3. Time of Death 11:25 AM
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	Funeral Director		1/0-32-31/2	ex 7. Age	(In yrs. last		Inder 1 Yeer nths Deys	If Under 24 H Hours M		th, 9y, Year) 5,1915	9. Birthple Counti Penns	ace (Stete or Foreign y) y1vania
	aryland show ed.at		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, To	own or Location	n				10	d. inside City Limits
	r 28a-f show notified at	ctor	Maryland Montgo	omery	Ch	evy Cha	ise					1 No Yes 2 No
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	Physician /Medical Examiner	er	23a. Pert1. Entar the disease, or com shock, or heart feilure. List only Immediata Cause (Final disease or condition resulting in deeth)	e. LUN	G CANC							Interval Batween Onset and Death
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Ţ	5 00	То Ве	examiner?	Hospitel: 1 Inpatien	it 2□ER/	Outpatient 3	DOA Ott	200	leeth <i>(Check only o</i> Home 5 ☐ Resi		er (Specify))
on of	ing After Tune		27. Manner of Deeth 1 K Naturel 5 Panding 2 Accident investigation	28a. Deta of Injury (Month, Day	Year) 28t	o. Time of Injury	28c. Inju	ryat rk? Yas 2 □ No	28d. Describe	how injury occur	red	
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Cartifier (Check only one) (Check only one) (Check only one)	ysician: To the best of hiner: On the basis of end menner stat	exemination	ge, deeth occu end/or investig	irred et the til etlon, in my d	me, dete and pla opinion, death oc	ca, and due to the curred at the time,	cause(s) and me data and plece,	enner as sta and due to i	ited. the cause(s)
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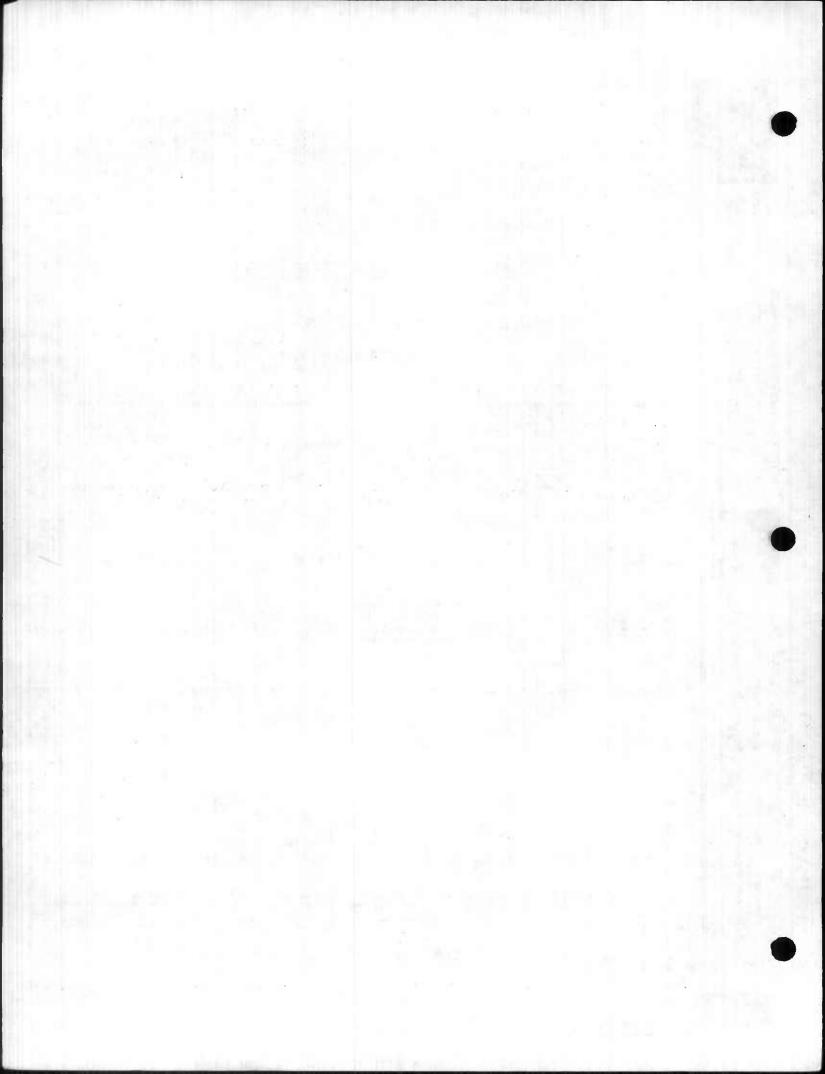


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3.01 pr July 26, William Watson Fenimore, Jr. 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 10XM 2□ F Months 90 October 25, 1908 | Pennsylvania Director 162-03-4930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notified 1 X Yes 2 ☐ No Directo Garrett Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Status 23a 11311 Kenilworth Avenue 20896 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Merried 2 Married 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates: þ 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hisd within 7 Hygiere. other then "n United States Elementery/Secondary (0-12) College (1-4or 5+) Government 4 Writer / Editor Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event 17. Father's Name (First, Middle, Last) 8 William Watson Fenimore, Sr. Nettie May Smeltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Robert Fenimore / son 14010 Esworthy Road, Germantown, Maryland 20874 20b. Piece of Disposition (Name of cametery, crematory or other place) July 31, Date 1999 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ABurlel 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility M00831 mmullen Faurence Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Darba 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of) Examiner LICHOUSH Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury Due to (or as a consequence of): ROLLOGS Physician/Medical that initieted events resulting in death) Lest Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert It. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? Primore LOA 2 No 1 ☐ Yes Ø No 25. Wes case reterred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: A Inpatient 2 ER/Qutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No edical Certification: To 27. Menner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accided 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Mospital or Att within 24 hours after of To the Funeral Direct 4 Homidid Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifie (Check o 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signaty 6 7-210-99 HJ1280 D address of person who completed cause of death (Item 23a) (Type, Print) 30. Neme and DASCAR ANUSH 13219 PEREUTIVE TERRADE CAFERDANIEUN HOZOBAY BYEK 31. Dete tiled (Month, Day, Year) 32. Registrar's Signeture State ecreva 3 0 1999 Registrar

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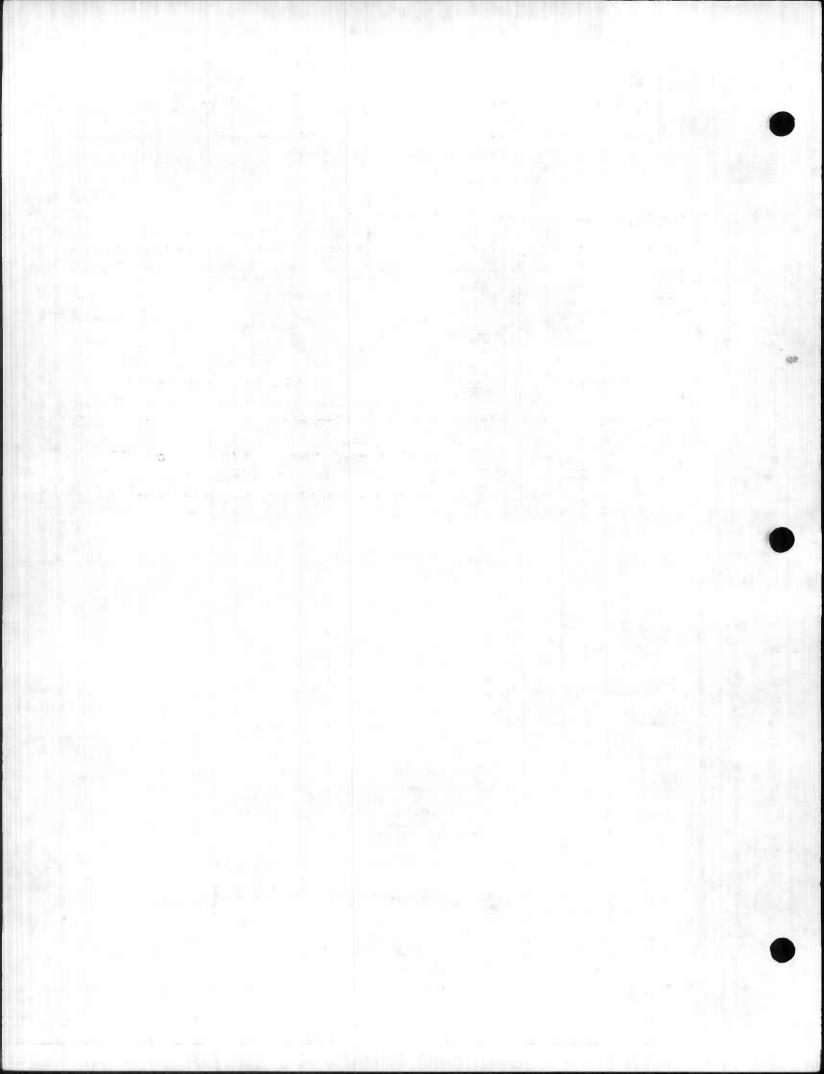
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 21, Dr. Joseph T. Forster 1999 4:45 PM. /Medical 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charter Health Care Silver Spring 8. Dete of Birth Month, Day, Year an, 4,04 Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 11 M 2 □ F 95 Yrs. 577-54-4451 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at show 1 Yas 2 No Maryland Directo Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code b 1316 Fenwick La. #523 20910 United States Barra 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Rece - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify: P 3€Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 ahouid be filled wh Department of Health and Mental Hygien Important: If them 27 is marked other tha any Injury or other treumetic aware 5+ Dentist Medical 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Aaron Forster Minnie Rosenwasser 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 9916 Bedfordshire Ct. Potomac, MD. 20854 Dr. Norman Forster/son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 2 Burial 2 Cremation 3 Removel from State B'nai Israel Cem, 7/23 Oxon Hill, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Library 22. Name and Address of Facility Takoma Funeral Home. 254 Carroll St. NW. Washington, DC. 20012 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer feilure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immedieta Cause (Finel Cardiomyopath disease or condition resulting in death) Examiner Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of) Box 68760 Physician/Medical Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? advanced age completion of cause of death? cachexia 1 ☐ Yas 2 ☐ No Be 25. Was case raferred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 27. Mannar of Death 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of Medical Certification: 1 Naturai 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicida Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signeture and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 - Silver Spring, his 8760 Georgia Ruth Cohen 31. Dete filed (Month, Day, Year) 32 Registrer's Signeture State

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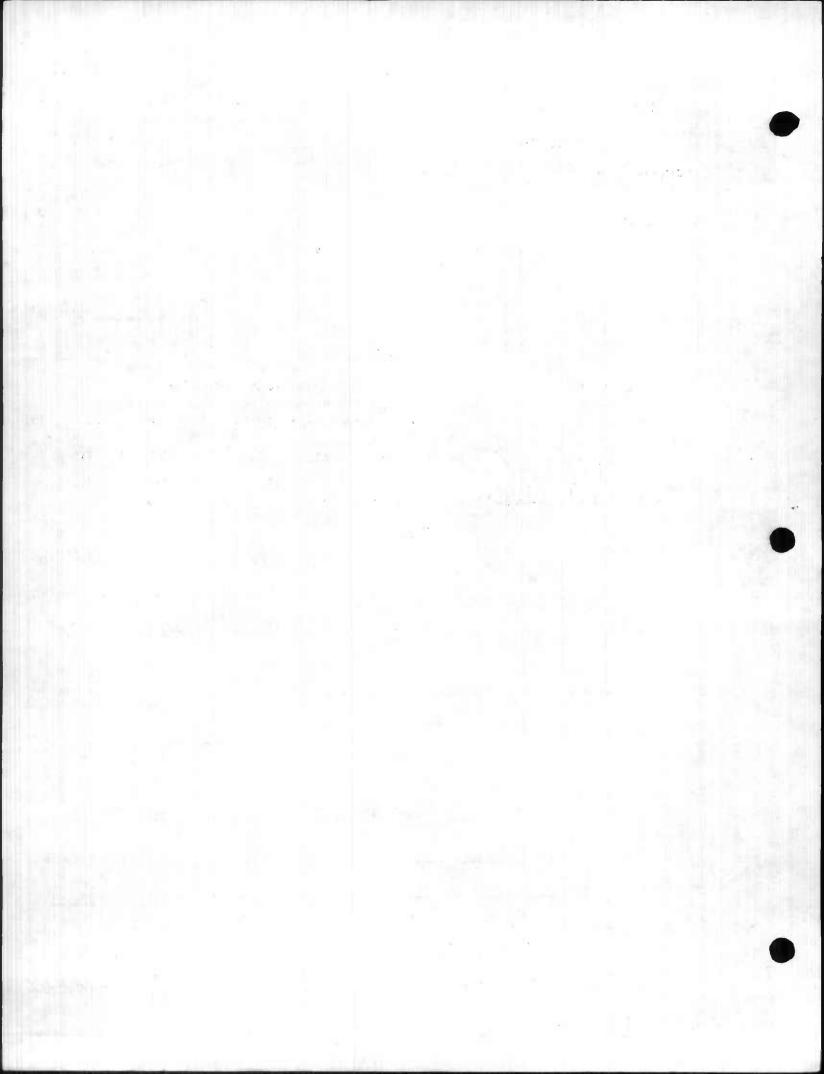
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Time of Death JULY 27, Day 1999 Year **Physician** 9:25 AM FRIEDMAN IDA /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner MONTGOMERY BETHESDA SUBURBAN HOSPITAL 8. Dete of Birth Mooth, Day, Year) JAN. 5, 1904 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birtholace (State or Foreign **Funeral** Months 1□ M 2□ F Days Hours WASHINGTON DC 95 Director 219-54-7693 Usual Residence of Decedent the Maryland 10a Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow must be notified at 1 ☐ Yas 2 ♥ No Director MARYLAND MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ UNITED STATES 5225 POOKS HILL ROAD #712S 20814 Norma 23a Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaer or Detas: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Maritel Stetus Biack, Whita, atc. 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 "natural", or Specify: WHITE 1 ☐ Yes 2 ☒ No Specify: P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Health and Zehould be fill Health and Mental H lem 27 is marked off Be "UNKNOWN" JULIUS PECK MOLLIE 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health as Important. If Rem 27 is 5225 POOKS HILL RD.#819S - BETHESDA, MARYLAND 20814 C. JAY SIMON (DAUGHTER) 20a. Method of Disposition 20b. Ptece of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stete Pages tent of P 1 ∑Burial 2 ☐ Cremation at ☐ F 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GDNS. 7/29/99 OLNEY, MARYLAND 21. Signature of Funeral Se ce Licensee 22. Neme and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852 23a. Pert1. Enter the disaesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear feiture. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** disease or condition resulting in deeth) /Medical O MORTINE Examiner Due to (or as a consequence of): ROW myopathy Examine 7-5CHB MIC physician and the burial-transit Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lsst OPONALL Physician/Medical to (or es a consequence ō 23b. Did tobacco use contribute to the cause of death? Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings avsilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peed 1 Yes 2 2000 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to andical examiner? Be 26. Place of Deeth (Check only one) Hospitel Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menney of Death 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Neturei 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide the Hospital 29e. Cartifier edical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and addre s of person who completed cause of deeth (Item 23a) (Type, Print) Posterfice Kap stotl ans otto 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar 3 0 1999

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one) and manner stated.									29d. Date signed (Month, Day, Year)					
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			HOLY CROSS	HOSPITAL				The same of the sa	SPRING	MO	NIGO	MERY
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	and *	1	Usual Residence of Decadent 10a. State 10b. County		10c. City, To	wn or Lo	cation			_	1	Od Incide Ob. Links
	the Maryland 28a-f show	5		1 Const	Too. Oily, To	WII OI LO					1	0d. Inside City Limits 1 Yes 2 □ No
	the Mar 28s-f si	Director	MD. MONTGO	MEKI			OLNEY			40.000 410		
	with B or		18 MORNINGW	OOD CT.			10f. Zip Code	20832		10g. Citizen of V	S.A.	try?
	tar death Items 23	Funeral	11. Maritel Status	12. Was Decedent	Ever in U,S.	13.		of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No	- 14. Rec	a - Americ	
21215-0020	or ite	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorcad	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Yeer or Dates:			f Yes, specify Ci		rto Rican, etc.)	Specify	k, White,	etc. ACK
0-0	"naturel",		15. Decedent's l	Education	16	Sa. Deced	dent's Usual Occ	cupation ne during most of wo		16b. Kind of Bu		
215	hin a	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or :		(Give life. I	kind of work dor DO NOT use ret	ne during most of wo ired)	orking			
2	T3 C0 by 100)OH	Elonovitally/ Octobridaty (U-12)	4	J+)	(CIVIL EN	GINEER		W.	S.S.(3.
pu	be filed ital Hygid d other	Be (17. Father's Neme (First, Middle, Les	t)				18. Mother's Na	me (First, Middle,	Meiden Sumam	10)	
Maryland		10	MILTON	GRAHAM					VIOLA	В	LACK	FIT
a	s 1 and 2 should f Health and Mer fem 27 Is marke other traumatic	ľ	19a. Informant's Name/Relationship	(Type, Print)	1	9b. Maitlr	ng Address (Stre	el end Number or A	lurei Route Numbe	er, City or Town,	Stete, Zip	Code)
_	and and m 27 I		JOYCE GRAHAM/	WIFE		SAL	ME AS	ITEM #10)			
altimore,			20a. Method of Disposition	75 1/ 0			sition (Neme of natory or other p	***	Date	20c. Location -	City or To	wn, State
Ĕ	permit. Pages Department of I Important: If Ite any injury or of once.		1 ☐ Burial 2 M Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				S CREMAT		7/26/99	RIVERD	ALE.	MD.
alt	Departit. Departitimporta		21. Signature of Funeral Service Lice	7300	_	22	. Name and Add	fress of Facility	11 177		,	
B	88 = 88		12/12/11/11/11/11/11/11/11/11/11/11/11/1	rm/sus/de	M0009	CI	LAMBEDO	דא בוייות וייד	TOMBO TO	Daring	TOTO AT T	E, MD.20737
	Physician /Medical Examiner	iner	Immediate Ceuse (Final disease or condition resulting in death)	. USE	Due to (or as	e consec	luence of):	EMORA DISSOLU	MASE E ALR	MAL (CLOT	Mouks
c 68760,	leath certificate be executed attending physician and d for use as the burial-transit	Medical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	С.	Due to (or es							
Box		an		σ								
0	0 0 %	Physician/	Part II. Other significent conditions	contributing to death b	ut not resulting	in the u	nderlying cause	given in Part I.	23b. Dld 1	obacco use cor	tribute to	the cause of death?
Δ,	requires that the death een signed by the atte hould be detached for	by Phy							10	Yes 2 No	3 Prot	ably 4 Unknown
Records,	aw requir is been si 2 should	Completed I								en eutopsy rmed?	eva	re eutopsy findings illable prior to apletion of cause leath?
R	0 - 5	Com							101	res 2 No	1 🗆	Yes 2 No
Vital		Be (25. Was case referred to medical					26. Place of De	ath (Check only o	ne)		
f V	2 00	To	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/0	Dutpatien	3 DOA	Other: 4 Nursing I	Home 5 ☐ Resid	dence 6 □Othe	er (Specify)
on of			27. Manner of Death 1 ☑ Netural 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Inju (Month, Da		. Time of Injury	V		4	now injury occurr		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not determined		ury - At home, c. (Specify)	farm, str	eet, factory, offic	:0	28f. Location (5 City or Tox	Street end Numb vn, State)	er or Rura	Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical	29a. Certifier 1 ☐ Certifying P (Check only one)	hyaician: To the best miner: On the basis of end manner sta	examination a	ge, death and/or inv	occurred at the restigetion, in my	time, date end place y opinion, deeth occ	e, and due to the urred at the time,	cause(s) end ma date and plece, a	nner es st and due to	sted. the ceuse(s)
	To th To th comp	Me	29b. Signeture and title of certifier				29c. Lice	nse number		29d. Date signed	(Month	Pay, Year)
	1.		Dotrun	CUSA	y m	1	777	6344	_	7-27	7-8	9
	12		30. Neme and address of person who	completed cause of d	eath (Item 23a) (Type,	Print) /-	PATRICI	A GU	RNY,	M.D.	
			HOLY CR	055 15	USPI	VIJ	-, 3	SILVER	SPRIN	a, Mo	(
	Sta Registr		31. Date filed (Month, Dey, Yeer)		er's Signature	4	1			,		

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Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5:44 p.m COFOSS Alphonso 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death MEDICAL CENTER 7. Aga (In yrs. last birthday) ANNAPOLIS ANNE ANNE ARUNDEL ARUNDEL If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Days Hours Min. 1₽M 2□ F Months 78 215-14-7237 TUNE 14 1921 MARYLAND Usual Rasidance of Decedant 10c. City, Town or Location 10b. County 10d. Inside City Limits Myes 2□No MARYLAND ANNE ARUNDEL ANNAPOLIS 10a Street and Number 10f Zin Corle 10g Citizen of What Country? 137 O'BERRY COURT 21401 US 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: W W 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced W.W.II 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tife. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry STATE HIGHWAY Elementary/Secondary (0-12) Collega (1-4or 5+) 10th LABORER ADMINSTRATION

Maryland 21215-0020 Pages 1 and 2 should be fivement of Health and Mental Hisart: If them 27 is marked offi 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) LUCILLE A. GROSS (WIFE) 137 O'BERRY CT. ANNAPOLIS, MD. 21401 mportant: If Item 27 altimore, 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2€ Cramation 3 ☐ Ramoval from Stata 7/23/99 BALTIMORE, MD. METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A. D. Kees 821 WEST ST. Lanny ANN APOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical a. Respiratory Arrest
Due to (or as a consequence of): Examiner Examiner Colon physician and the burial-transit the death certificate be executed Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Box 68760, Depsis Physician/Medical Dua to (or as a consequence of): 980 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 12(Yes 2 No 3 Probably 4 Unknown artery Records, þ 24a. Was an autopsy performed? Completed has page certificate of Vital 25. Was casa rafarred to medical axaminar? Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28b. Tima of 28c. Injury at Work? After Division 5 Pending invastigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifian (Check only one) 29c. License number 29b. Signature and title of certifier H005284 3 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

1 Yas 2 No 1 □ Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Data signed (Month, Day, Year) - 23-99

18. Mother's Name (First, Middle, Maiden Surnama)

20c. Location - City or Town, Stata

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

year

6 months

weeks

NANCY BROWN

DR SWALLY 180 Admiral Cochrane

Drive, Amapolis

State Registrar

Physician

/Medical

Examiner

10a. Stata

17. Father's Nama (First Middle Last)

UNOBTAINABLE

Funeral

Director

28a-f show

8

Name 23a

'natural', or

72 hours after

filed within 7 Hygiene.

Director

à

Be

31. Data filed (Month, Day, Year)



IL 20 1000 por p. force

1	Exam
	Funera Directo
timore, Maryland 21215-0020	. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiena. Interest Is marked other than "natural", or flema 23a or 28a-1 show jury or other traumatic avent, the Medical Examiner must be nontraid.

Physician /Medical Examiner physician and s the burial-transit law requires that the death certificata be axecuted Division of Vital Records, P.O. Box 68760 ned by the a sign. should t certificata has t director, page 2 s Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completaly filled in by the

Certificate of Death 2. Data of Daeth 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Day Month **Physician** DAVID WILLIAM HERSHEY JULY 26 1999 10:07AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth iner 10880 Maryland Point Road Charles Nanjemoy If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Undar 1 Yaar 5. Sociel Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foreign Country) Days 1**∑** M 2□ F Months 577-03-1733 Yrs. 85 Aug. 12, 1913 Maryland Usual Residence of Decedent 10a, Stata 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Charles Directo Nanjemoy 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 10880 Maryland Point Road 20662 U.S.A. Funeral 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Wes Decedent Evar in U,S. Armed Forcas? 14. Rece - Amarican Indian, 11. Marital Status Black, Whita, atc. ☐ Yas 2 No Yas, Give 1 Nevar Marriad 2 Married 1 Yas 2X No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Coilege (1-4or 5+) Radio & TV Repair U.S. Air Force 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be David Royer Hershey Leila Ethel Mummar 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Edna E. Hershey/Wife 10880 Maryland Point Road, Nanjemoy, Maryland 20662 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from Stata Data 20c. Location - City or Town, Stefa Huntt Crematory 7-28-1999 Waldorf, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Address of Facility
The Huntt Funeral Home, Inc. 21. Signiture of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, App shock, or heart failure. List only one cause on each line. Approximata intarvai Batween Onset end Deeth Immadiata Causa (Final Ischemic Heart Disease disaasa or condition resulting in daath) Due to (or es e consequence of): Acute Myocardial Infarction Examin Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated avants resulting In death) Lest Dua to (or as a consequenca of): Physician/Medical Dua to (or as e consequença of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown by 24b. Wara eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performad 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical Be 26. Placa of Daath (Check only one) exeminer? Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 70 1 Yas 2 No 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 1. Naturel 5 Panding 1 Yas 2 No Investigation 2 Accidant 6 Could not be detarmined 3 Sulcida 28a. Placa of Injury - At homa, farm, straaf, factory, offica building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Cartifian edicai 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number 7-27-94 folia Tagam M.D M. D-50883 30. Name and addrass of person who complated causa of death (itam 23a) (Type, Print) No. Names and address of person who completed causa of death (Ham 23a) (Type, Print)

Yahia M. Tagouri, MD St. Mary's Hospital Dept. OF Pathology 25500 Pt. Lookout Road

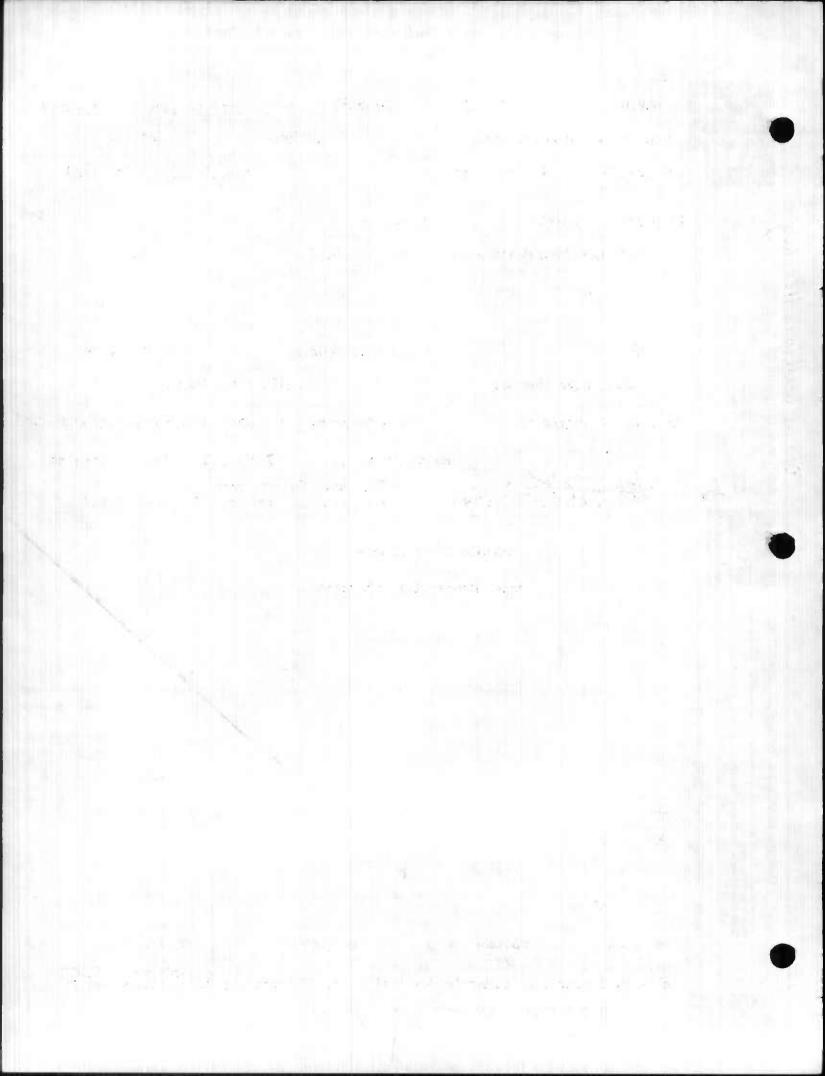
32. Registrar's Signatura

Registrar

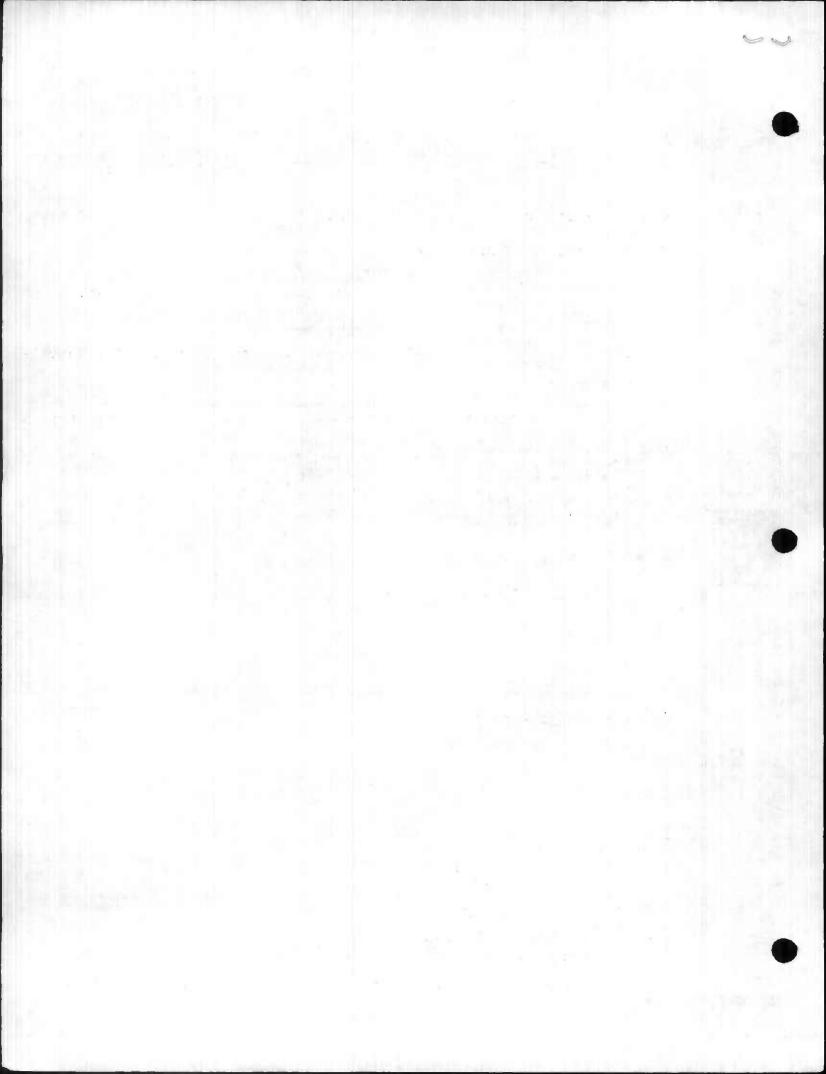
State

31. Data filed (Month, Day, Year)

JUL 3 0 1999



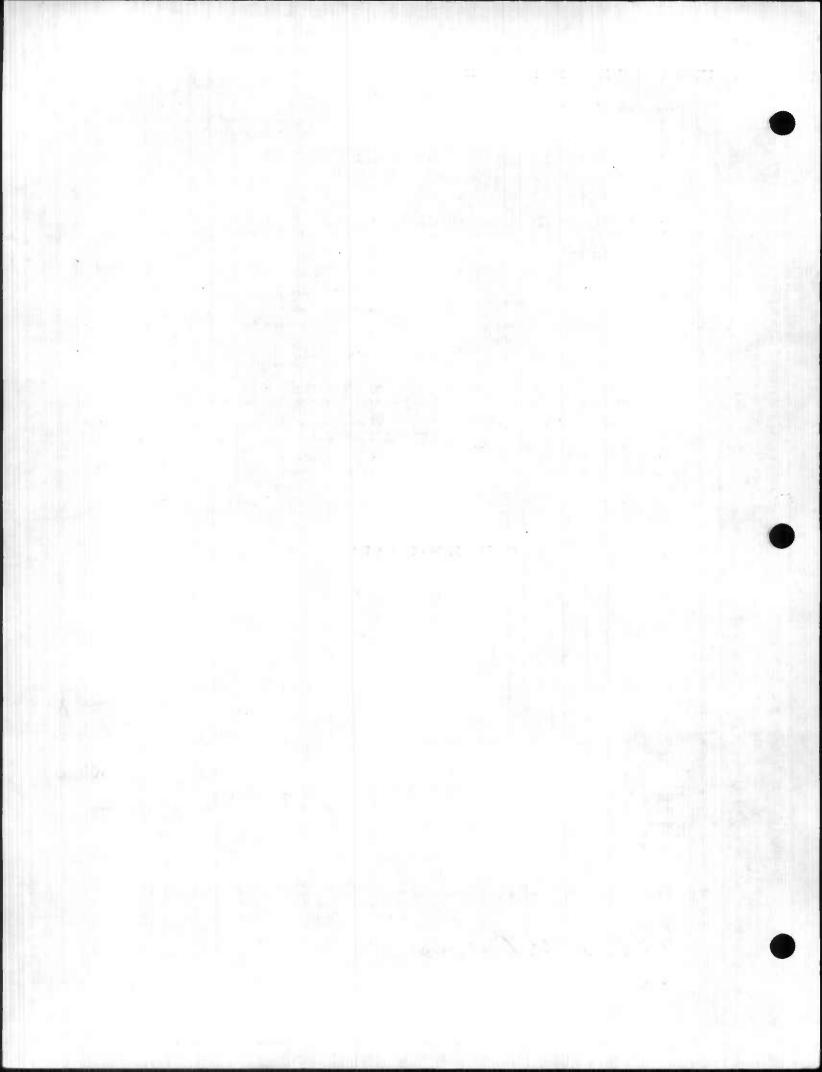
_	Decedent's Name (First, Middle, L.	ad)		Certificate of	Death	2. Dete of De	Reg. No.	3 6.0	ime of Death
Physician	JOSEPH		HARPER			JULY	19, Day 199	Year 7	:05 AM
/Medical Examiner	4a Facility Name (If not Institution, gi				4b. City, Town, or	1			
	Collingwood N	Nursing &	Rehab	Center	Rockv	ille	LUOW	GOMERY	
Funeral Director		Sex 7. Age 125M 2□F	(In yrs. last birt	hday) If Under 1 Year Months Days			Y. Year 1908	9. Birthplace (S Country) Mary	land
D 2 11	10a. State 10b. County	I	10c. City, Town	or Location				10d. Ins	ide City Limits
the Maryland 28a-f show sottlind at ector	MD Montgo	omery	P	oolesvill	е			10%	Yes 2□No
E 9 E	10e. Street and Number 18640 Jerusa	alem Churc	ch Roa	d 10f. Zip Code	20837		10g. Citizen of V	What Country?	
Ura sher de st., or hems Examinar or by Fune	3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? PE Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 2 No		pecify Yes or No o Rican, etc.)	Blac	e - American Indi kk, White, etc. Black	
1 21215-0 ed within 72 ho hygiene. At the Medical.	15. Decedent's E (Specify only highest gr		16a.	Decedent's Usual Occu (Give kind of work done	during most of wor	tking	16b. Kind of Bu	usiness/Industry	
TS Han Han	Elementary/Secondary (0-12) 8th	College (1-4or 5+		ille. DO NOT use retire	*	~~~	Monto	Co C	
C Hand	17. Father's Name (First, Middle, Last	()	B	ld Servic			Maiden Sumam	Co. S	chools
hould be fill Mental H marked off matte even						hel Ha			
ary and with	19a. Informant's Name/Relationship	(Type, Print)	19b.	Meiling Address (Stree	t and Number or Au	ıral Route Numb	er, City or Town,	Stete, Zip Code)	20837
F = 24 .	Evelyn E. Harp	per (Wife)		18640 Jer					
or office of the state of the s	20a. Method of Disposition *XXBurial 2 Cremetion 3 [4 Donation 5 Other (Speci		cemeter	Disposition (Name of y, cremetory or other pla alem Chur		7/24/		City or Town, St.	
Deperment Paragraphics of the Paragraphics of	21. Signature of Funeral Service Lice	med Just	d Que	22. Name end Addr SNOWDE ROCKVI	ess of Facility N FUNER LLE, MD	AL HOM	E, P.A.		
	23a. Part 1. Enter the ensease, or corr shock, or heart fallium. List only	plications that caused I	the death. Do n		•			Appro	oximeta et Between
Physician		4							t and Death
/Medical Examiner	Immediate Cause (Finat disease or condition resulting in death)	. 51RO	KE						
	resolving at dealing			onsequence of):					
min at		b. RENA	CFA	CORC					
onect n enc fal-fra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	L	rue to (or es a c	onsequence of):				t i	
68760, fleate be executed physicien end a the burtal-transit edical Examiner	Cause (Disease or injury that initiated events	c	ue lo (or as e c	onsequence of):					
death certificate be executed to the control of the	resulting in death) Last		,					i	
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is, P.O. BOX (et that the death certificated by the enending be detached for use at by Physician/Mc	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause g	iven in Pert I.	23b. Did	tobacco use co	ntribute to the c	ause of death?
P.O. that the detache	ASPIRATION PI	JEOMODIA				1 🗆	Yes 20 No	3 Probably	4 Unknown
Hecords, P. C he law requires that the t has been signed by th iga 2 should be descon mpleted by Phys							an autopsy	24b. Wera aut	
w require						perf	ormed?	available completic of death?	on of cause
E : 5 5						10	Yas 2 No	1 ☐ Yes	20-No
VITAL Ician: The contilicate sector, page Co.	25. Was case referred to medicat				26. Place of Dec	eth (Check only			
Physici this co- rai direct	axaminer?	Hospital: 1 Inpatien	t 2 ER/Out	patient 3 DOA	ther: Nursing H	lome 5 Res	idence 6 Oth	er (Specify)	
D Harry Harr	27. Manner of Death 1-BNatural 5 ☐ Fending	28a. Date of Injury (Month, Day		ime of 28c. Injury	ury at ork?	28d. Describe	how injury occur	red	
VISION OF VITS Attending Physician: Indeeth. ector: Atter this certific by the funeral director, lification: To Be (2 Accident Investigation	250		M 10	Yes 2□No				
DIVISION C bell or Attending P re shar deeth. al Director: Attert led in by the funeral	3 Suicide 4 Homicide			m, street, factory, office		28f. Location City or To	(Street and Numb wn, Stete)	per or Rural Rout	a Number,
he Hospi in 24 hou he Funer pletsly fill edical	29a. Certifier (Check only one) TE Certifying Pl	hysician: To the best of miner: On the basis of and mariner state	mamination and	dwith occurred et the t investigation, in my	ime, date end place opinion, deeth occu	e, end due to the erred et the time.	cause(s) and ma date end place,	annar as stated. and due to the co	tuse(s)
Som M	290. Signature and title of certified	MXV	UM	11/2	280		29d. Dete signe	d (Month, Day, Y	ear)
	30. Name and address of person who ANCSH DOAGAR	completed cause of de DO 13219	XECUTIV	ype, Print)	PRACO 6	ERMAN	TOUN. M	10 2087	74
State	31. Date filed (Month, Day, Year)	32. Registrar		. Sports					1
Registrar	JUL 2 6 199	19 Some	_ /	. sporks					
DHMH 16 Rev 6/95		100							



MARK ANDREW HANNA 45 Edity Marker (find institution, gws street end number) 34.22 GREEN CASTLE RD. 5. Social Security Number 45. City, Town, or Location of Death & Country of Death MONTCOMERY 5. Social Security Number 5. Social Security Number 10. Size 10. Country 10. Size 10. S	ian	1. Decedent's Name (First, Mid	OIO, LES	11)				rtificate c				2. Date of Month		Day	Year	3. Time of Deat
3.4.2.2 GREEN CASTLE RD. 3. Social Security Number 6. See 102M 21 F 7. Age (in yrs. last beforeign) 1. Use 12 19-96-1663 1. The security Number 1. 100 County 1. Security Number 1. Security	ical				um her)				41	. City. Toy	vn. or Lo					1830
219—96—1663 100 Cerrity 100 C	er				_											RY
Description Control		5. Social Security Number			7. Age	(In yrs. la						8. Dete of	Birth Day, Yo	ear)	9. Birthp	piace (State or Fore
100. Sizes and Number			11	LXM 2LIF		_31_	Yrs.						-			
PARTY ATTA Monther 100. Street and Number 100. Zp Code 100. Citizen of What Couring? 100. Street and Number 100. Zp Code 100. Citizen of What Couring? 100. Street and Number 100. Zp Code 100. A first Couring? 100. A first Couring. 100. A firs			ty			10c. City,	Town or Lo	ocation							1	0d. Inside City Lin
1 Marial States 1 Was Decedent Ever In U.S. 1 Was Decedent States 1 Was Decedent	ğ	Maryland Montg	omer	·v		Burt	onsvi	11e								1 ☐ Yes 2 🙀
1. Martia Statics 1. Was Decodered Ever in U.S. 1. Was Decodered Ever in U.S. 1. Was Decodered to Hispanic Chipn (Specify Vas or No- Black, White, such 1. Chips (Price, Specify Cubin, Nescoat, President Resource) 1. Was Decodered of Hispanic Chipn (Specify Vas or No- Black, White, such 1. Was Decodered of Hispanic Chipn (Price, Specify Cubin, Nescoat, President Resource) 1. Was Decodered of Hispanic Chipn (Price, Specify Cubin, Nescoat, President Resource) 1. Was Decodered of Hispanic Chipn (Price, Specify Cubin, Nescoat, President Resource) 1. Was Decodered (Price, Specify) 1. Was	lrec		011102		1	Dare	.0110 1 1		ie				10g	. Citizen of V	Vhat Cour	ntry?
Security Specify Spe		3422 Greencas	tle	Road				20866					USA	A		
Securities Sec	į			Armed F	Forces?		6. 13.	Was Decedent of If Yes, specify C	of His	spanic Orig	in? (Spe Puerto I	cify Yes or Rican, etc.)	No-			
15. Decedent's Education 16. Decedent's Education 16. Decedent's Usual Coccupation 16. Education 16. Education 16. Decedent's Usual Coccupation 16. Education				If Yes, G	Sive -	0		1 ☐ Yes 2 ☐	No	Specify:				Specify	Whi	te
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State of Maryland / Department of Health and Mental Hygiene 99 25 1 23

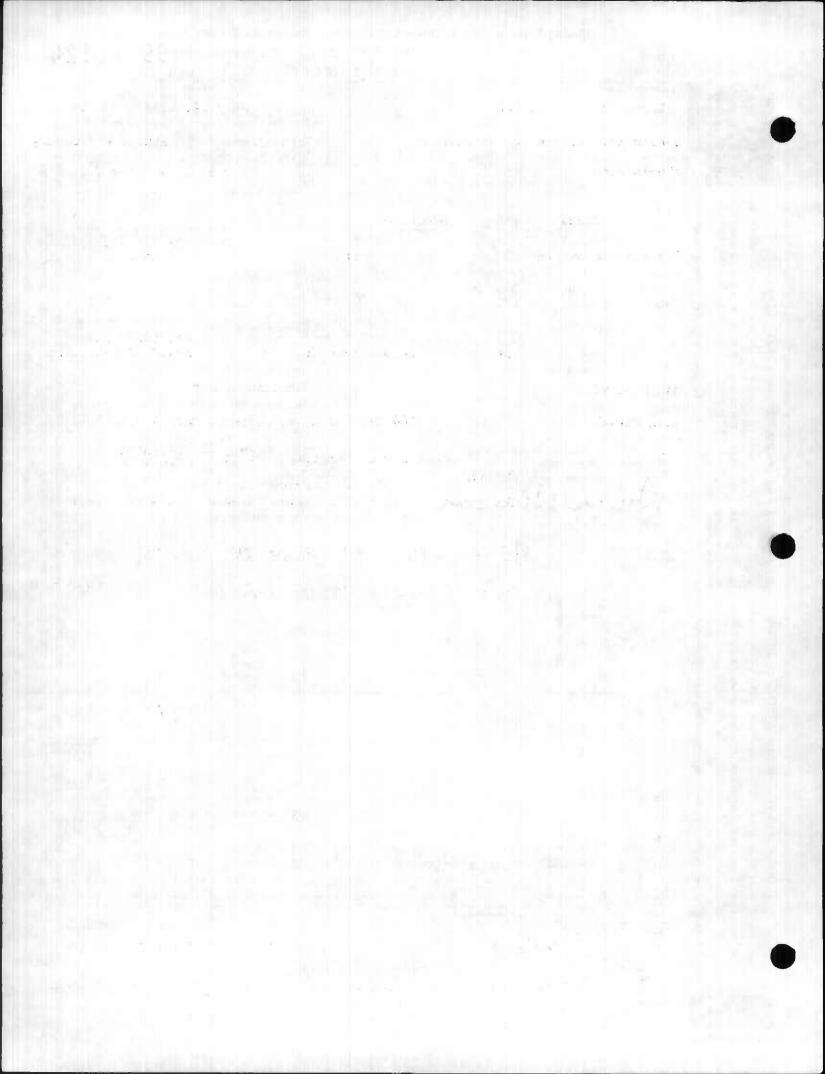
			Certific	cate of		· · · · · · · · · · · · · · · · · · ·	Reg. No.	20	120
	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath	Year 3.	. Time of Death
Physician /Medical	William C. Hanson	, Jr.				July	29 19	99 1	2:50 a.m.
Examiner	4a Facility Name (If not institution, give	street and number)		- 4	lb. City, Town, or	Location of Death	4c. County	of Death	
	Woodside Center			S	Silver Sp	ring	Montg	omery	
Funeral Director	5. Social Security Number 6. Se 577-14-9421	7. Age (In yrs. 82		inder 1 Year iths Days	If Under 24 Hrs Hours Min.	8. Date of Bird (Month, Date 11 1	h y. Year) 7 16	9. Birthplace Country) Illino	(State or Foreign
2 .	Usual Residence of Decedent 10e. State 10b. County	10- 0	ity, Town or Location					104.1	harlds Oiby I lavins
the Maryland 28s-f show notified at	MD Montgome		ckville						Inside City Limits 1 Yes 2 No
vm no Ma or 28s-f s be notified Director	10e. Street and Number		101	. Zip Code			10g. Citizen of W	hat Country?	
w 42 ag 18	11125 Schuylkill R	oad		20852			USA		
5-0020 72 hours after death with the Marylas natural; or learn 23e or 28e+1 show that Examiner must be notified at steed by Funeral Director	1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? PDSYes 2 No If Yes, Give Year or Dates: 8/1	0110	ecedent of H specify Cubi es 2000	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Bleck Specify:	- American Ir k, White, etc. Whit	
	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Decedent's (Give kind o life. DO NO	Usual Occup	ation during most of wo	rking	16b. Kind of Bu	siness/Industr	У
d 2121 fled within Hygiene, ther then mit, the Ma	Elementary/Secondary (0-12)	College (1-4or 5+)	Securit				NIH		
	17. Father's Name (First, Middle, Last)		Decarie	y oddi		me (First, Middle,		e)	
Viano Wental H Mental H Mental H Mental H To Be	William C. Hanson	Sr.			Minna H	I. Schaf	er		
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event	19a. Informant's Name/Reletionship (T)	rpe, Print)	19b. Meiling Add	iress (Street	and Number or Re	ural Route Numb	er, City or Town,	State, Zip Coo	de)
and 2 is a seath ar trau	Kathleen Hanson /		11125 Sc				-	20852	
of Tas Tas Office of the search	20a. Method of Disposition	20b	Piace of Disposition	(Name of	1	Date	20c. Location -		
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Departition of the control of the co	21. Signature of Funeral Service Communications	Scerlo			sity Blvd				MD 20901
Physician /Medical	23a. Part . Enter the disease, or compl shock, or heart tailure. List only or Immediata Cause (Finel	ne cause on each line.	th. Do not enter the	mode of dyin	g, such as cardia	c or respiratory e	rrest,	Inte	proximate erval Between set and Daath
Examiner	disease or condition resulting in death)	Arrhythmia							
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or Attending Physicien: The law requires that the death cer dier death of after death. But ontificate hes been signed by the estendir I in by the fundral director, page 2 should be deteched for used tification: To Be Completed by Physician/Aertification: To Be Completed by Physician/Aertification:	Stroke, Atrial	fibrillation	1				an autopsy med?	availat	autopsy tindings ble prior to etion of cause th?
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tor, p	25. Was case referred to medical				26. Place of De	ath (Check only o	nne)		
hysicle his cent il direct	axaminer? 1 Yes 2€No	Hospital:	ER/Outpatient 3[DOA Oth	er	lome 5 Resi	THAT IN THE	er (Specify)	
Attending Physician: Attending Physician: Attending Physician: Attending Physician: Attending Physician	27. Manner of Death 12∑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	1	how injury occurr					
LIVISION C tall or Attending P re effector: Affect at Director: Affect and in by the funer Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ctory, office		28f. Location (: City or To	Street and Numbern, State)	er or Rural Ro	oute Number,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this cartificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp		sician: To the best of my knoner: On the basis of examination and manner steled.							
Withir To the Comp	29b. Signature and title of certifier	er 29d. Date signed			Year)				
25+1	4. Une	elleur		24	2578		July 29	. 1999	
2571	30. Name and address of person who co							,	
	Gul Chablani, 106			212, 5	Silver Sp	oring, M	D 20902		
State Registrar	31. Date filed (Month, Day, Yeer) JUL 3 0 199	32. Registrar's Sign		book					

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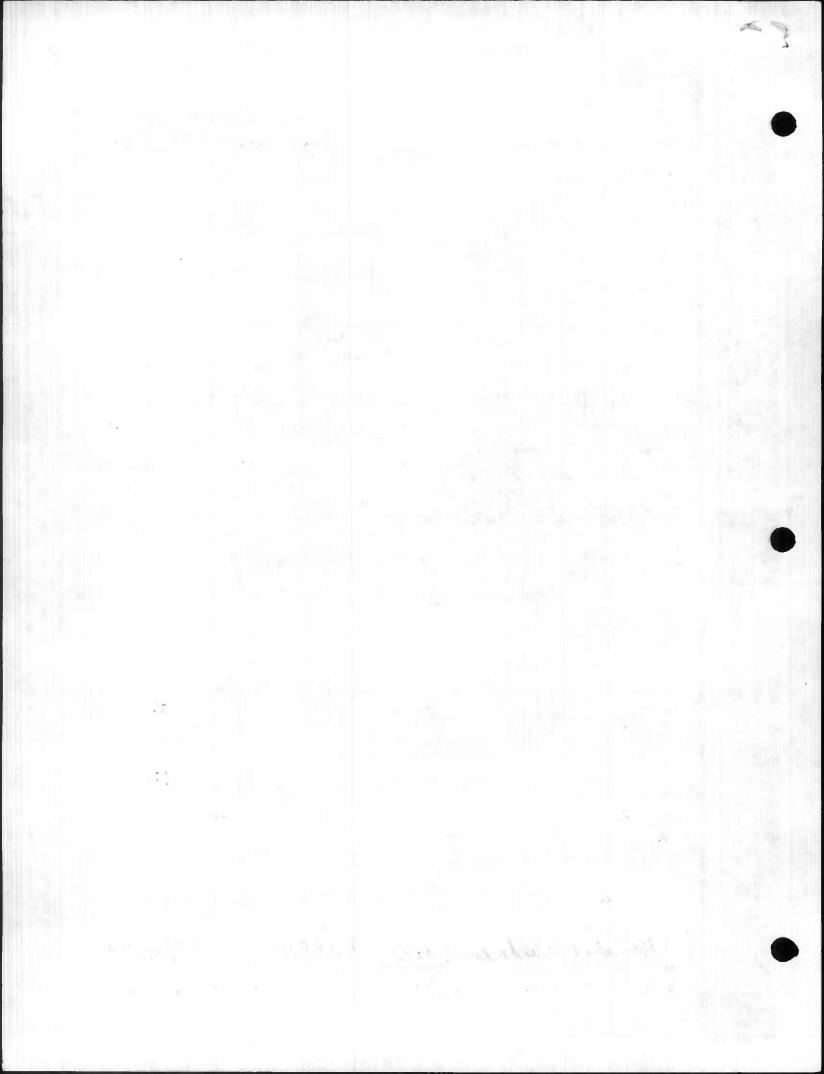
State of Maryland / Department of Health and Mental Hygien 9 25 1 2 4

	Decedent's Name (First, Middle, La	Death	2. Date of Death 3. Tim										
Physician		Hirsch	July 24, 1999		1:43 A.M.								
/Medical Examiner	4a Facility Name (If not institution, gin					4b. City, Town, or		-					
Cxaminer	Hebrew Home of Gr	reater Wash	ington			Rockvil	le	Montg	gomery County				
Funeral Director	5. Social Security Number 6.		(In yrs. lest birt		er 1 Year s Days	If Undar 24 Hrs Hours Min.			9. Birthplace (Stete or Foreign Country) New York				
2	Usual Rasidence of Decedent		40.00 7						Tana and an an an				
Merylei H show	10a. State 10b. County New Kings		10c. City, Town						10d. Insida City Limits 1 ☑ Yes 2 ☐ No				
with the Mei 3s or 28s-f s If De notified	10e. Street and Number 464 Neptune Avenu	16			ip Code			10g Citizen of W United of Amer	hat Country? States				
11215-0020 within 72 hours effer death with the Meryland ene. than "naturel", or items 23s or 28s-f show he Medical Examiner must be notified at sympleted by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 N		13. Was Dec		dispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)		- American Indian, c, White, etc.				
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1 21215-002 led within 72 hours of tygiene: new heaturel', con it, me wed call Eng	(Specify only highest gr.	111111111111111111111111111111111111111	Collaga (1-4or 5+)			pation during most of wo d)	MON TOL		k City f Education				
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Baltimore, Maryla Family, Peper 1 and 2 should Bepertment of Health and Man Important: If them 27 is marke any injury or other treumatic Pages 1 and 2 should Depertment of Health and Man To any injury or other treumatic	Max Moskowitz		Cornelia Scharf										
	19a. Informant's Name/Ralationship	(Type, Print)				and Number or R							
	20a. Method of Disposition		8204 Raymond 20b. Place of Disposition (Neme of cemetery, crematory or other p				Date	20c. Location - 0	City or Town, State				
	12 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci		Mount Hebron Ceme				July 20		ng, ck				
	21. Signature of Funeral Service Licansee #M00690 22. Name and Address of Facility. Nieberg Midwood Chapel 11230 1625 Coney Island Avenue, Brooklyn, New York												
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
	Immediate Cause (Final disease or condition resulting in death)	STATIO	ATIC CARCINOMA OF					Criset and Death					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated avants	b. A) ENO CARCINOMA OF BR Dua to (or as a consequence of):					REAS	T	16 YEARS				
		c	Due to (or as a c	onsequenca o	1):								
deeth cert deeth cert e attendin ed for use							1						
P.O. BOX het the deeth cert d by the attendin stetched for use Physician/N		contributing to death bu	23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown										
Vital Records, P.O. Box lician: The lew requires that the deeth cent certificate has been signed by the attendin rector, page 2 should be detected for use Be Completed by Physician/N								s an autopsy omed?	24b. Were autopsy findings available prior to completion of cause of death?				
Vital Rec								Yas No	1 ☐ Yas 2 ☐ No				
/itc	25. Was case referred to medical examiner?	Hospital:			Oil	hor \/	ath (Check only						
the state of		1 Inpatient 2 EH/Outpatient 3 DOA 4 Num					ing Home 5 ☐ Residence 8 ☐ Other (Specify) 28d. Describe how injury occurred						
Division Tor Attending I after death. Director: After d in by the fune	1 Natural 5 Pending 2 Accident Investigation	(Month, Dey Year) Injury Work? 1 □ Yes 2				rk?]Yes 2□No							
Division of the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	3 ☐ Sulcide 4 ☐ Homicide 3 ☐ Sulcide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State)												
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29a. Cartifiar (Check only one) 10 Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and due to the cause(s) and mannar as stated. 20 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the causa(s) and manner stated.												
Vithin To the comple	29b. Signature and title of cartiller	. 0		29d. Date signed (Month, Dey, Year)									
10	· dilla) (80						84 JULY 24, 1999 D. Rockville, MD 20852					
	30. Name and address of person who	completed causa of de	eath (Item 23a) (Type, Print)	ros	SE RD	Rocki	rille, M	020852				
State	31. Date filed (Month, Dey, Year)	32. Registre	ar's Signature	4	20 4	,							

DHMH 16 Rev 6/95



	ot1&2,7/30/99, EMW, Montg.Co. Certificate 1. Decedent's Neme (First, Middle, Last)								2. Date of Month					Year	3. Time of De		
Le	Leonard Anthony Huguley											28,	1999		9:41 1		
4a Fac	ility Neme (If r	not institution,	give street	and number)				4	lb. City, Tow	n, or Lo	cation of De	ath	4c. County	of Death	18		
	05 Wood		Avenu						ilver				Montgo				
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months						If Under 1 Months (Year Days	If Under 24 Hours					lace (State or Fi			
	-58-932	, CX/ ,	39 Yrs.					Oct. 8, 1959 DC									
	Usual Residence of Decedent 10a. Stete 10b. County				10c. City, T	own or Loc	cation						10	Od. Inside City I			
Max															1 Yes 2		
2 -	Maryland Montgomery 10e. Street and Number				Silver Spring							10g. Citizen of What Country		trv?			
3705 Woodridge Avenue 20902																	
	11. Marital Stetus							cedent of Hispanic Origin? (Specify becify Cuban, Mexican, Puerto Rica			cify Yes or	IUS.	14. Rac	e - America			
tX	to Never Married 2 Merried			1 ☐ Yes 2/Fl/No								k, White, e					
3 ☐ Widowed 4 ☐ Divorced			M				U Yes 2	Yes 2 No Specify:			Specify:		Whit	White			
	(S	5. Decedent's	s Education	cation 16a. Decedent's t			ent's Usual (s Usual Occupation				16b. Kind of Business/Industry		lustry			
3 Elem	(Specify only highest grade completed) (Give kind of work life. DO NOT use						work done during most of working Tuse retired)										
							er Te	Technician				Computers					
17. Fat	her's Neme (F	irst, Middle, L	ast))				18. Mother's Name (First, M			(First, Midd	Middle, Maiden Sumame)					
Mau	rice An	ndrew H	lugule	guley					Patricia H. Alva			var					
	forment's Nem					19b. Mailin	g Address (S	Street I	and Number	or Rural Route Number, City or Town, State, Zip Code)							
	n J. Hu	0	Brot	her	3	705 W	Voodri	dge	Ave.,	Si				MD 20902			
	ethod of Dispo		3 □Remov	rel from State	20b. Place	e of Dispos etery, crem	sition (Name natory or other	of er plac	09)	į.I	uly 3		c. Location -	City or To	wn, State		
	Donetion 5				Metro	polit	an Cr	ema	tory		999		lexand	ria,	VA		
21. Sig	neture of Fund	eral Service	ponsee	1			Name and			20	Funor		Home, I				
	Inu	8	16	erlo		50	O IINI	J.	od to P	115	runer.	al.	nome, 1	nc.	. MD 20		
23e. P	act. Enter the	diseese, or of	omplication	ns that caused t	23e. Paper Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, index or heart fellure. List only one cause on each line.												
	STARTS OF IMMUTERIUM. LIST Only one cause on each line.											y arres	-		Intervel Between		
Immediate Cause (Final diseases or condition as Recurrent lymphoma, brain (probable, no biopsy)									g, such as ce	ardiac o	r respirator	yarres			Intervel Betwee Onset and Dea		
disees	e or condition	inal													Intervel Between Onset and Dea		
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disees	e or condition ng in death)	inal	aR	ecurren o cquired	t 1ym	phoma s a consequence de), brai	n ((probal	ole,				3 0 1 1 2 4	011001 0110 000		
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State of Maryland / Department of Health and Mental Hygiene

99 25126

			Certificate of	of Death	Reg	No.	_ 0 0				
	1. Decedent's Neme (First, Middle, La	ist)			2. Date of Death	Davi Vasa	3. Tima of Death				
Physician	DIANE V.	HOWARD			JULY 26	1999 Year	0625				
/Medical Examiner	4a Facility Name (If not institution, gh	re street and number)		4b. City, Town, or L	ocation of Death	4c. County of Deat	th				
LAditille	ANNE ARUNDEL M	FDICAL CENTS	סק	ANNADOLI	re	ומג שוווא	INDET				
5		Sex 7. Age (In yrs.		ANNAPOL] par If Under 24 Hrs.	8. Date of Birth	ANNE ARU					
Funeral Director		1□M 2♀F	Yrs. Montha De	ys Hours Min.	(Month, Day, Yo		hplece (State or Foreign ountry)				
Director	219-38-1301 Usual Residence of Decedent	57_			MAY 20	1942 MAR	RYLAND				
B 8 11	10a. State 10b. County	10c. Cit	y, Town or Location		10d. Inside City Limits						
Mary Media	MARYLAND ANNE A	RIINDEL AND	NAPOLIS			1 🗆 Yes 2					
th with the Marys 23e or 28e-f sho ust be notified at ral Director	10e. Street and Number	THE PROPERTY OF THE PROPERTY O	101. Zip Cod	in .	100	10g. Citizen of What Country?					
E 22 C	1	DOAD			109						
Tal Mark	433 BROADNECK			401		US					
her death r hems 23 stost must Funeral	11. Marital Stetus	 Wes Decedent Ever in U, Armed Forces? 	,S. 13. Wes Decedent of If Yes, specify C	of Hispanic Origin? (Sp Suban, Mexican, Puerto	oecify Yea or No- o Rican, etc.)	14. Race - American Indian, Bleck, White, etc.					
	1 Never Merried 2 Merried	1 Yes 2 No	1 ☐ Yes 2 🕅	No Specify:	Specify: BLACK						
Exa.	3 Widowed 4 Divorced	Yaar or Detes:	21								
er than "natur 4, the Medical Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Decedent'a Usuel Oc (Give kind of work do	cupation ne during most of work	king 16	b. Kind of Business/	Kind of Business/Industry				
up In	Elementary/Secondary (0-12)	College (1-4or 5+)	'life. DO NOT use re	tired)	-	AY MANOR NURSIN					
State of	9th	0	NURSE AI)	H	OME					
d othy	17. Father's Neme (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Me	iden Surname)					
o fice	EARL HOWA	RD	FLOF	RINE COLBERT							
DEE .	19a. Informent's Neme/Reletionship	Type, Print)	ural Route Number, City or Town, State, Zip Code)								
	JENNIE HOWARD (COUSIN)	1439 MIDDI	LETOWN RI	o. ANNAPOLIS, MD. 21401						
E 6	20a. Method of Disposition		Place of Disposition (Name of		7	c. Location - City or					
5 = 5	1 Surial 2 Cremation 3	JHemoval from Stata	emetery, cremetory or other								
the state of	4 □ Donation 5 □ Other (Special		. CALVARY CI		1E. 7/31	199 ARNO	LD, MD.				
NA POR	21. Signature of Funerel Service Lice	nsee	22. Name end Ad								
OFER	WM. REESE & SONS MORTUARY, P.A.										
- 4	23a. Part1. Entar the/disease, or con	lications thet causad the deat	h. Do not enter the mode of	dying, such es cardiac	or respiratory arrest	MD. 21	Approximata				
vsician	shock, or heart feilure. List only	une cause on eech line.					Onset end Death				
ledical	tmmediete Cause (Final	(= = = :									
aminer	disease or condition resulting in death) a. 5 C S t S Due to (or es a consequence of):										
- T	Due to (or es a consequence of):										
n end ial-transit Examiner	-	b. aspira	//	umanio							
X.	Sequentially list conditions, if any, leading to immediate	Due to (o	or as a consequence of):								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c				j					
F F	that initiated events resulting in death) Last	Due to (or									
AMe as		4									
attending p if for use as clan/Mex	_	0.									
	Pert II. Other significant conditions of	contributing to death but not res	given in Pert I.	23b. Did toba	to the cause of deat						
ed by the attended for undeteched fo	211	, ,	1 ☐ Yes	robebly 4 Unkno							
aigned de de de de de de	Dispetes ou	T of Control	STrok								
S D D			1 (1)		24a. Wes en e	outopsy 24b.	Were eutopsy finding				
page 2 should	Hypertensic	n renal	performe	evailable prior to completion of cause							
mpl		/ /		of death?							
Page P	peripheral 4	rescaler di	iscase		1 ☐ Yea	2 No	1 ☐ Yes 2 ☐ No				
rector, pa	25. Wes case referred to medical examiner?			26. Plece of Dec	th (Check only one)						
this can directly the c	1 ☐ Yes 2 No	Hospitel: Inpatient 2	ER/Outpatient 3 DOA	Other: 4 Nursing H	ome 5 Residence	e 6 Other (Spe	ocity)				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1											
fune fune fune fune	1 Netural 5 Pending investigation										
Director: A i in by the fi	3 Suicide 6 Could not be determined	286. Piece of injury - At no	ome, farm, street, fectory, offi	ice		et and Number or Ri	urel Route Number,				
al Director: After to In by the funers Certification:	4 Homicide	building, etc. (Specify	y)		City or Town, S	31010)					
	29e. Certifier 12 Certifying Pt	nyelclan: To the best of my kno	wlades death assumed at the	a time, data and place	and due to the cour	na/a) and manner a	n stated				
pletely fill		niner: On the basis of axamine	tion and/or investigetion, in m	ry opinion, deeth occu	rred et the time, date	and plece, and due	e to the ceuse(s)				
Med Med		end manner stated	204	Data dan dan	the David Manual						
000	29b. Signature and this of certifier	101	ense number		29d. Date signed (Month, Dey, Year)						
	Mar.	L mo	1)4/0/6	o 7/26/59 afer Annapolis MD 2							
	30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)	. 0. /	14	Fraultin	54.				
	Charles Wilhe	1	e Arundol N	Tederal Com	ter a	MANOLIC	MD 214				
State	31. Date filed (Month, Day, Year)	32/Registrer's Signe	iture 🗸 🛕	- /	, , ,	-	1				
State Registrar	MM 2 6 199	1 Denne	1. 6	21							

from p. foods

JUL 3 0 1999

State of Maryland / Department of Health and Mental Hygiene 99 25 127

		C	ertificate of	Death		Reg. No.	20121
Diam'r lain	Decedent's Neme (First, Middle, Last)				2. Date of Dea Month		3. Tima of Deeth Year
Physician /Medical	Alice Teresa Hammond					7, 199	
Examiner	4e Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Death	4c. County o	f Death
	Anne Arundel Medical			Annapol			Arundel
Funeral Director	1□ M 2XF	n yrs. last birthde 71 Yrs.	Months Days		8. Date of Birth (Month, Day	(, Year)	9. Birthplace (Stete or Foreign Country) New York City
	112-22-7473 Usuel Residence of Decedent				0000	4,1521	New TOTA CIE
S W	10a. State 10b. County 1	Dc. City, Town or	Location				10d. Inside City Limita
Mar Hed	Maryland Anne Arundel	Annapo]	lis				1 ☐ Yes 2 No
desith with the Maryland rms 23a or 28a-f show rmast be notified at heral Director	10e. Street and Number		101. Zip Code			10g. Citizen of WI	hat Country?
The will be set to set	103 Groh Lane		21403		Ţ	United S	tates
	11. Marital Status 12. Wes Decedent Eve Armed Forces?	or in U,S. 1	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No-	14. Race	- American Indian, , White, etc.
	1 Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 2 No		o thous, olony		white
Examily d by	3 M Widowed 4 □ Divorced Yeer or Dates:					эреспу.	
t, the Medical	 Decedent's Education (Specify only highest grade completed) 	16e. De	cedent's Usuel Occu ive kind of work done s. DO NOT use retire	pation during most of wor	rking	16b. Kind of Bus	iness/industry
dm dm	Elementery/Secondery (0-12) College (1-4or 5+)		ner/Operat			Food Se	razion
	1 2 17. Father's Name (First, Middle, Last)	OWI	ler/Operat	T	ne (First, Middle,		
Be o	John Otto			Teresa	Tewes		
2	19e. Informent's Neme/Relationship (Type, Print)	10h 84	eiling Address (Stree			r City or Town	State Zin Corle)
	Jean Ludwig (Sister)		Groh Lane				
		20b. Place of Dis	sposition (Neme of		Dete		City or Town, Stete
	1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)		vary Cemet		1/99	Emmone	New York
injury *	21 Gegasture of Funeral Service Licensee	Mc. Cal					eral Home, Inc.
9 8	Round Out in Fo	Val	147 Duke	of Cloures	ster St	Annapol	is, MD 21401
	23a. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line.						Approximeta
cian	snock, or neart tellure. List only one ceuse on eech line.						Intervel Between Onset and Deeth
ical	Immediate Cause (Final disease or condition	to (troke				6 days
ner							1 3 2 3
je je	Haerose	derotiz	sequence of): - Cesebro	vascular	- Diseas	-	
erre ouractionsit		e to (or es a con:					
	Cause (Disease or injury						
edicai	thet initiated events resulting in death) Last	e to (or es e cons	sequence of):				
2	d						
Physician/	Pert II. Other significant conditions contributing to death but n	ot constitue to the	a undadvina naven n	ives in Deat I	225 Dide	ahanaa uaa aani	tribute to the cause of death?
detached	0		a underlying cause g	IVON NI FOILT.	100		3 Probably 4 Unknown
by P	Cormany Arkey Dize	250			A		
					24a. Was	an autopsy med?	24b. Were autopsy findings available prior to
Completed					po		completion of cause of death?
Com					101	es 2 No	1 ☐ Yes 2 ☐ No
0	25. Was casa referred to medical			26. Place of Dec	eth (Check only o	ne)	
To B	examiner? 1 Yes 2 No Hospitel: 1 Inpatient	2 ER/Outpa	tient 3 DOA O	hor	lome 5 Resid		r (Specify)
	27. Menner of Death 1 Metural 5 Pending (Month, Dey Y.)	28b. Time		iry at	28d. Describe t	now injury occurre	d
in by the funer ertification	2 Accident investigation			Yes 2□No			
led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury building, etc. (/		street, fectory, office		28f. Location (S City or Tow		r or Rurel Route Number,
S S							
pletely lill edical	29a. Certifier (Check only Medical Examinar On the basis of ex	aminetion and/or					
completely lilled in	one) and manner states 29b. Signature and title of coatiler	3.		se number			(Month, Day, Year)
8	1/1/1/4/	4.0					
	Millein Vogler	MO		28283		July ?	-01
	30. Negle and address of person who completed sause of deel William H. Rogers MD, 600 Ridge	h (Item 23a) (Tyr		Brugodis,	MD 214	01	
State		Signature	,	7 - /		,	
State egistrar	JUL 2,9 1999	- b	Since				
			500.00				

NUL 2, 3 1999 Somme S. April

State of Maryland / Department of Health and Mental Hygieneq q 25128

			Ce	ertificate of	Death		Reg. No.	20120		
Plantata.	1. Decedent's Name (First, Middle, Last)					2. Date o		3. Time of Death		
Physician - /Medical	ARTHUR E. HA	LL				JULY		1.777		
Examiner	4a Facility Name (If not institution, give s					own, or Location of D	Death 4c. County	of Death		
	1107 EASTPORT			T WILL TO A VICE		POLIS	ANNE ARUNDEL			
Funeral Director	5. Social Security Number 6. Security Number 219-26-3265	7. Age (In yr.	s. last birthday Yrs.	Months Day		Min. (Month	, Day, Year)	9. Birthplace (State or Foreign Country) MARYLAND		
ath with the Meryland 23a or 28a-f show wat be notified at ral Director	10a. State 10b. County MARYLAND ANNE A		NAPOL					10d. Inside City Limits 1 Yes 2 □ No		
vith the Me or 28a-f a be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?		
3a o	1107 EASTPORT	TERRACE		21	403		US			
ofter death v		12. Was Decedent Ever in	U,S. 13.	Was Decedent of	Hispanic Or	igin? (Specify Yes o	r No- 14. Rac	ce - American Indian,		
Dy by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ↑ Year or Dates:		1 Yes 2 N		n, Puerto Rican, etc.	Specif	ck, White, etc.		
1 21215-0 ed within 72 ho vygiene. ver than "natura rt, tre Medical Completed	15. Decedent's Educ (Specify only highest grade		(Giv	edant's Usual Occi	e during mos	st of working	16b. Kind of B	usinass/Industry		
A C . M -	Elementary/Secondary (0-12)	College (1-4or 5+)	lifa.	DO NOT use ratio	ed)					
il Hygie other th	12th 17. Fathar's Name (First, Middle, Last)	2 yrs.	MAII	NTENANC		ora Nama (First Mi	PIONER ddla, Maiden Suman			
Be Be								10/		
Aarylan 2 should be 5 end Mentel ie marked of eumatic eve	PHILLIP HALL	D-i-n	10h 14e	Una Addana (Čta)		CHEL BRO		State 7in Code)		
, Nand	19a. Informant's Name/Relationship (Ty, PAMELA HALL (WI)	FE)	110	7 EASTPO		ERRACE A	ANNAPOLI	s, MD. 21403		
Baltimore	20a. Method of Disposition 1 Burlal 2 ☑ Cremation 3 □R		cemetery, cre	position (Name of ematory or other p	ace)	Date		- City or Town, State		
Peg ment	4 ☐ Donation 5 ☐ Other (Specify)	M	ETRO (CREMATO	RY	7/28/9	9 BALTI	MORE, MD.		
Balt permit. Depart Import any inj once.	21. Signature of Funeral Servica Licanse	99	1	22. Name and Add			omila par	D 3		
m %05%a	Lavry H.	Beese					RTUARY,			
	23a. Part1. Enter the disease, or compli- shock, or heart fail re. List only on	cations that caused the de	ath. Do not er	nter the mode of d	ing, such as	cardiac or respirate	ory arrest,	Approximata Interval Batween		
Physician /Medical	Immediata Causa (Final disease or condition			4	A	retie		Onset and Death		
Examiner	resulting in death)		(or as a conse							
P # S		10/180	00	ABU,	PE					
58760, cete be executed physicien end s the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	equenca of):						
E 00	Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a conse	equenca of):						
Box eath cert for use		l								
P.O. het the de deteched by the deteched Physic	Part II. Other eignificant conditions con	tributing to death but not re	asulting in tha	undarlying cause (jiven In Part			ontribute to the cause of death? 3 Probably 4 Unknown		
ord require seen si hould		,				24a.	Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause		
f Vital Rec ystclen: The law is certificate hes b director, page 2 s							1□ Yes 2.2 No	of death?		
= F # 0	25. Was casa raferred to medical				OC Piles			1 185 2 140		
Of Vital Physician: The this certificate ral director, pa	evaminer?	lospital:		all post	thor:	e of Death (Check o	Rasidanca 6 □Ott	has /Casaiks)		
0 4 5 5	27. Mannarof Death	1 ☐ Inpatient 2		BUT SEL DON	4 🗆 14		ribe how injury occur			
After fune	1-□Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury		ork? ⊒Yes 2.⊑]No				
Division of standing Plus after deeth. at Director: After the do in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not be datermined	28a. Place of Injury - At building, etc. (Spec	home, farm, s			28f. Locat	on (Street and Num. r Town, State)	ber or Rural Route Number,		
Division or To the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7		sician: To the best of my kiner: On the basis of examinand manner stated.								
To the within To the comple	29b. Signature and title of certifier	· Noone	10	29c. Lice	nse number	1	29d. Date signe	ed (Mopth, Day, Year)		
	30. Nama and address of person who co	mplated cause of death (It	- 1 /	Print) font	M D	nië,	Annap	est is all 40		
State Registrar	31. Date filed (Month, Day, Year) JUL 2 8 19	32. Registrer's Sig	natura	6. 4.						
DHMH 16 Ray 6/95		,		1900	1		-,			

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THE PERSON

from the front

JUL 28 1999

State of Maryland / Department of Health and Mental Hygieng 9 25 | 29

					Cen	titicate	of D	eath			Reg. No.			110	
	_	Decedent's Name (First, Middle	. Lasi)						-	2. Dete of De Month	eth Dey	,	Yeer	3. Time of	Death
/sician ledical		Robert Mo	rine Huse	2						07	25			10:0	0 AM
miner	40	Facility Name (If not institution	give street end number	er)						ation of Death		County of			
		820 Coxsw				6.10	l.	Anna	-					undel	
	00	06 06 0698	6. Sex 1 NM 2 □ F	Age (In yrs. 75	last birthday) Yrs.	If Under 1 Months	Days Days	If Under 2 Hours	Min.	8. Dete of Bir (Month, De 09/04/			9. Birthpl Count Maine	* .	r Foreig
		sual Residanca of Decedent le. State 10b. County		10c. Cit	y, Town or Loc	ation							10	od. Inside C	tv Limits
č			mundal											1 🗆 Yes	•
ect	10	e. Street and Number	rundel	AIII	napolis	10f. Zip (Code			- 1	10a Citi	zen of Wh	net Count		2525
Funeral Director		820 Coxswain W				214	101				USA				
by		. Meritel Status 1 □ Never Merried 2 ☑ Merri 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2[If Yas, Give Yeer or Date	s? □No 194	1 -	/as Decede Yes, speci	21	panic Orig , Mexican , Specify:	gin? (Spec , Puerto F	city Yes or No Rican, etc.)			, White, e	an Indian, etc. nite	
ted		15. Decedent (Specify only highes			16a. Decede	ent's Usual	Occupeti	ion	of workin	a	16b. Ki	nd of Bus	iness/Ind	lustry	
Completed		Elementary/Secondary (0-12)	College (1-40	or 5+)	life. D	O NOT use	a ratired)	ing most	OF WOTAIT	9					
Con			4		Presi	dent								ciatio	n
Be (17	. Fether's Name (First, Middle, I	.est)				1	18. Mothe	r's Name	(First, Middle	Maiden	Sumame)		
0		Harry Huse						Flore	ence	Morine	2				
	19	a. Informant's Nama/Ralationsh	ip (Type, Print)		19b. Malting	Addrass	(Street en	nd Numbe	r or Rurai	Route Numb	er, City o	r Town, S	State, Zip	Code)	
		Marylou Huse (wife)		820 C	oxswa	ain W	lay,	Annar	colis_N	1D 21	401			
	20	a. Method of Disposition			Placa of Dispos	ition (Nem	ne of			Date	20c. Lo	cation - C	City or To	wn, State	
		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		te	ropoli				7	/26/99	Ale	exand	lria	VA	
	21	I. Signeture of Funeral Service I				Name end				20,55		A 101 10		422	
		DOLANDA D.	Mho							emation	n Ser	vice	es		
	-	3a. Part1. Enter the diseese, or shock, or heart failure. List	rander to see	and the deat	An Do not ente	napol	is M	D 21	401	reeniratory a	rroet			Approximat	9
n Il r	di	nmediate Cause (Final seasa or condition sulting In deeth)	. C.		or as a consaqu	uence of):								Onset and	20011
m m			- b. Di	ahed	es m	e//.	to								
Examiner	Se	equentially list conditions, any, leading to immediate		Y Due to (o	or as a consequ	Janca or):							1		
<u>e</u>	Cr	equentially list conditions, any, leading to immediete lusa. Entar Undarlying ause (Disease or injury at Initiated events	c	ed	som o	pate	7	-							
Medical	re	sulting in death) Last		Dua 10 (0	r es e consequ	ierica or):	_								
			d												
SICI	Pa	art II. Other significant conditio	ns contributing to death	but not res	ulting in the un	derlying ca	ause giver	n in Part I.		23b. Dld	tobacco	use conf	tribute to	the cause	of death
Physician/										10	Yes 2	□ No	30 Prot	oably 4	Unkno
Completed by										24a. Was	en eutopormed?	psy	ava cor	ere eutopsy allable prior mpletion of daeth?	to
ошо										10	Yes 2	No	10	Yes 2	No
BeC	25	. Was case referred to medical						26. Place	of Death	(Chack only	one)				
ToB		examiner? 1 Yas 2 No	Hospital:	atient 2	ER/Outpatient	3□ DO	A Othar	r: 4□ Nu	irsing Hor	na 5 Res	Idenca	6 □Othe	r (Specif	y)	
L:uc	27	. Manner of Death 1 Matural 5 □ Pending	28a. Date of I		28b. Time of Injury	28	8c. Injury			8d. Describe	how inju	ry occurre	ed		
Certification:		2 Accident investig 3 Suicide 6 Could r 4 Homicida	ation	Injury - At he	ome, ferm, stre	M et, factory,		as 2 🔲 I		28f. Location (Street er	nd Numbe	or or Rura	I Route Nur	nber,
F		9a. Cartifiar 1197 Certifyin	Physician: To tha be	st of my kno	wiedga, death	occurred a	at the tima								
ai Certi	29		xaminer: On the basis		tion end/or inv	astigation,	in my opi	inlon, dea	th occurre	ed at tha tima,	data end	d placa, a	nd due to	the ceuse(3)
edicai	29		end manner	Statou.		-									
Medicai Certi	29	(Check only 2 Medical I		stated.		29c.	. License	number			29d. De	te signed	(Month,	Day, Year)	
edicai	29	(Check only 2 Medical I		Stated.					7						
edicai	29	(Check only 2 Medical I	end manner		n 23a) (Type. F		DJ3		7			te signed			

25130

State of Maryland / Department of Health and Mental Hygiene	99
Certificate of Death Reg. No.	

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) MARTIN DAVID JOLLES 2. Date of Death 047nth27.1999 3. Time of Death

4a. Facility Neme (If not institution, give street and number)

6. Sex

HOSPICE OF BALIMORE- GIL CHRIST CENTER

1 M 2 □ F

4b. City, Town, or Location of Death 4c. County of Death

Min

BALTIMORE

If Under 24 Hrs.

12:58 AM

BALTIMORE COUNTY

Funeral

Usual Residence of Decedent 10b. County MARYLAND MONTGOMERY

If Under 1 Year Months Davs Hours 8. Date of Birth (Month, Day, Year) 07.20.1955

9. Birthplace (State or Foreign WASHINGTON, DC

Director

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Funeral

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Completed

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permit. Pages 1 end 2 Department of Health e important: If item 27 is any injury or other tree

Physician /Medical

Examiner

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detached signed by t

page 2

by

Completed

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Certification:

Medical

P.O.

Records,

Attending Physicien:

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death.

ofter deat Director:

To the Hospital of within 24 hours of To the Funeral D completely filled in

filled in by

with the Maryland

death items

hours after

Baltimore, Maryland 21215-0020

10c. City. Town or Location ROCKVILLE

7. Age (In yrs. last birthday)

44

10d. Inside City Limits

1 Yes 2 □ No

10e. Street and Number

5. Social Security Number

121.12.9247

11420 STRAND DRIVE #9

10f. Zip Code 20852 10g. Citizen of What Country?

11. Marital Status

 Was Decedent Ever in U.S. Armed Forces? Yes 2 No Year or Dates:

 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

1 Never Married 2 Married

3 Widowed 4 Divorced

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

MECHANICAL CONTRACTOR

AIR CONDITIONING/

17. Father's Name (First, Middle, Last)

MYRON JOLLES

18. Mother's Name (First, Middle, Maiden Sumame) JOAN JOLLES

19e. Informant's Name/Relationship (Type, Print)

BRIAN JOLLES/BROTHER

19b. Meiling Address (Street and Number or Bural Boute Number, City or Town, State Zip Code) 10408 HARDWOOD CT, WOODSTOCK, MD 21163

20a. Method of Disposition

1 Surial 2 Cremation 3 Removal from State

20b. Plece of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State

4 ☐ Donation 5 ☐ Other (Specify, 21. Signeture of Funeral Service Li

JUDEAN MEMORIAL GARDENS 7.29.99

OLNEY, MARYLAND

22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC.

23a. Part 1. Enter the disease, a complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line.

20852

Immediate Cause (Finel disease or condition resulting In death)

10 6 Due to (or as a consequence of) Approximete Interval Between Onset end Deeth

Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Physician/Medical

Due to (or as a consequenca of)

Due to (or as a consequence of)

thet initieted events resulting in death) Last

26. Place of Death (Check only one)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death?

20 No 1 Yes

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 1 Yes 2 No

27. Manner of Deeth 5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

Hospital:

Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Neturel

2 Accident

3 ☐ Sulcide

4 Homloide

😾 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

295. Signature and Itle of certifier

29c. License number mo

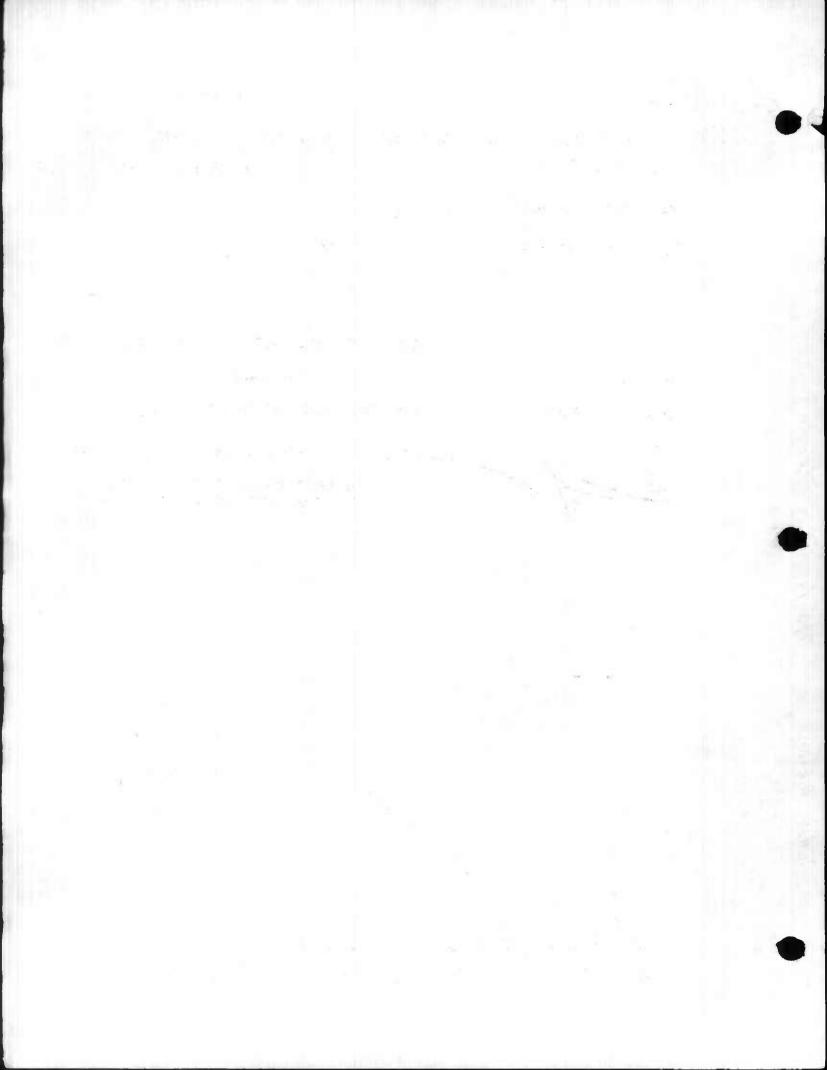
29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

JUL 29 1999

6701 N. Charles St. Balto, Md 21205 GBMC 32. Registrar's Signature

State Registrar

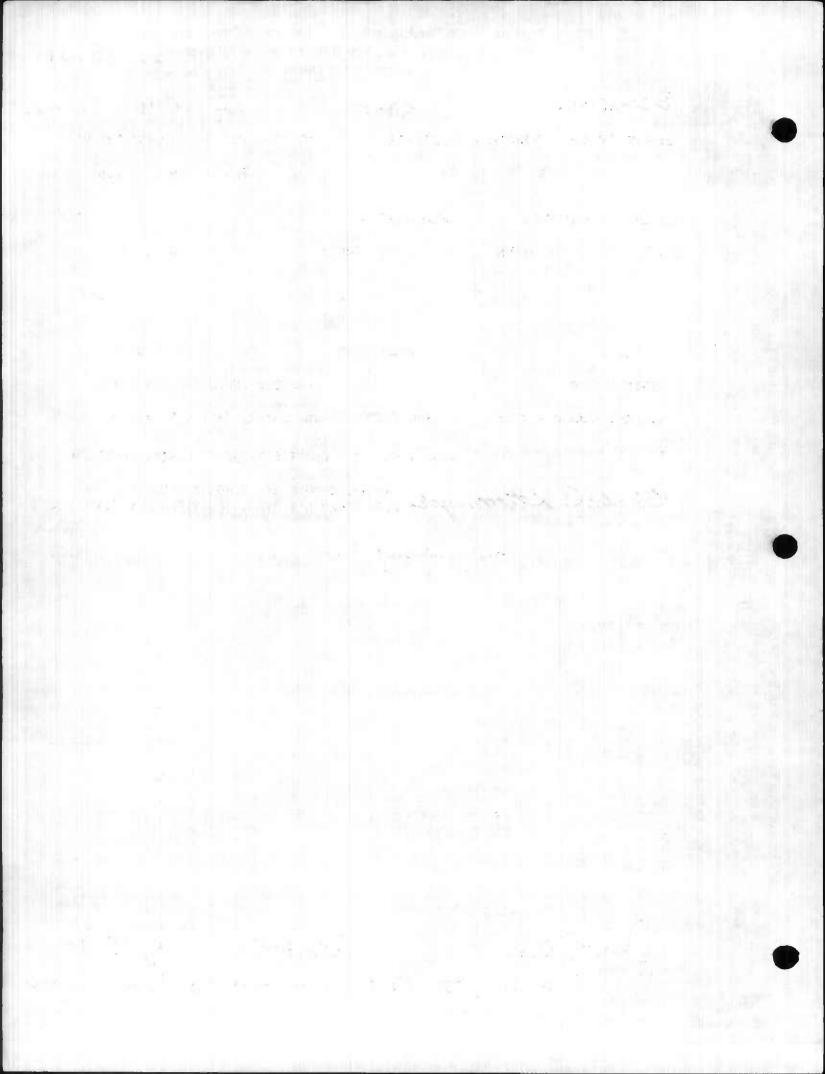


State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Yeer Month Physician 522-MOLLA 10:25 pu KAMJOS 24 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. lest birthday) Funeral Months Deys Hours 1₽M 2□F Yrs 213-02-8433 80 Director FEB. 4, 1919 IRAN Usuel Rasidence of Decedent death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or itema 23a or 26a-f show the Madical Evantings must be notified at 1 Yes 2 □ No MARYLAND MONTGOMERY GAITHERSBURG Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 20878 304 FLEECE FLOWER DRIVE U. S. A. Funeral 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? Raca - American Indian, Black, White, etc. 11. Meritel Stetus 1 ☐ Yes 2 No if Yes, Give filed within 72 hours efter 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry el Hygiena. Elamantery/Secondery (0-12) 12 YEARS Collage (1-4or 5+) ACCOUNTANT ACCOUNTING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mentel Hant: If item 27 is marked off Be REBBI KAMJOO KHATOON (UNASCERTAINABLE) 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) MONIREH KAMJOO - WIFE 304 FLEECE FLOWER DRIVE, GAITHERSBURG, MD. 20878 other 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Data 0 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stata permit. Page Department of Important: If any injury or pace. JUDEAN MEMORIAL GARDENS 7/25/99 OLNEY, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. eeth. Do not enter the mode of dying, such es cardiec of respiretory errast,

Approximate 23a. Pert1. Enter the disease, or complications that caused the shock, or heart fellure. List only one cause on each line Approximete Interval Between Onset end Death **Physician** Prolympholytic levicenis /Medical Immediata Causa (Final diseese or condition resulting in deeth) **Examiner** Examiner certificate be executed buriei-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Diseese or Injury that initiated evants resulting in deeth) Lest pue Dua to (or as e consequance ot): Box 68760. physician Physician/Medical the Due to (or es e consequença of) 80 for use signed by the a Pert It, Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy tindings available prior to completion of cause of death? 24e. Wes en autopsy Completed peen has page 2 1 Tyes 2 No 1 □ Yas 2 □ No certificate Division of Vital or Attending Physician: director, Be 25. Wes case referred to medical axeminer? 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpetient 3 DOA this funeral Dete of Injury (Month, Day Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After Naturel 5 Pending after deeth. Director: Aft 1 Yes 2 Accident investigetion 6 Could not be datarmined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide 24 hours 6 Hospital 29e. Cartifier Excertifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the cause(s) and mannar es stated. Medical pletaly ☐ Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at tha tima, data end place, and due to the ceuse(s) end menner stated. (Check only one) Within 2 To the 29c. License number 29d, Data signed (Month, Day, Year) 29b. Signatur end title of certifie 3 30. Neme and addrass of person who completed causa of daath (Itam 23e) (Type, Print) BUCCIA M MEDICA Conford 970 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture JUL 28 1999

Repers

State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 25 132

Certificate of Death

1. Decedent's Nema (First, Middle, Last)

KONSTANTINOS GEORGE KATSAFANAS

State of Maryland / Department of Health and Mental Hygiene 9 25 132

Certificate of Death
Month Month July 25, 1999

3. Time of Death July 25, 1999

Physician /Medical Examiner

Funeral Director

within 72 hours ahar death with ine Maryland sine. than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be liled within 72 hours after of
Department of Health and Mental Hygiene,
Important: If New 27 is marked other than "natural", or then
any injury or other traumetic event, the Medical Examinet

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be associted within 24 hours after death.

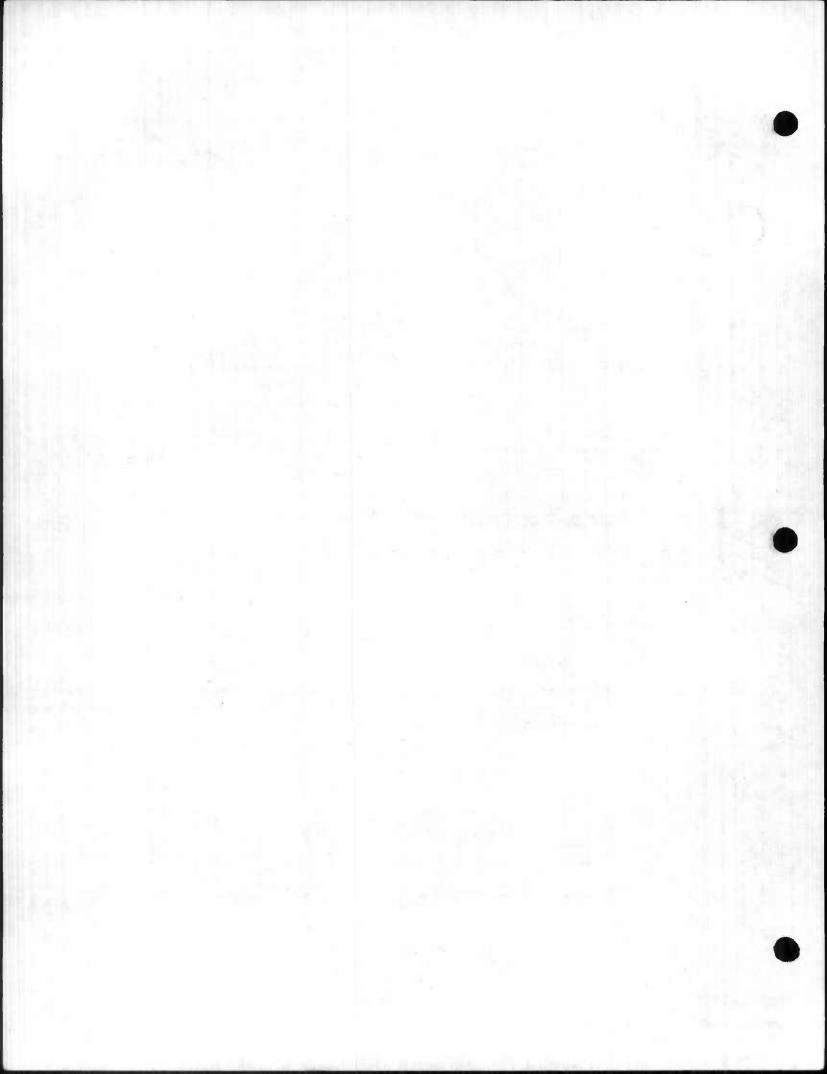
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunta-transit

Division of Vital Records, P.O. Box 68760,

KONSTANTINOS	GEORGE KA	ATSAFANAS			JÜLY :	25,1999	1	1:00 P.M
4e Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Dea	th 4c. County	of Death	
13104 FOXHALL	DRIVE			SILVER	SPRING	MONT	GOMERY	
333-40-/103	9x 7. Aga (In	yrs. last birthday) 78 Yrs.	If Under 1 Yaar Months Deys	If Under 24 H	rs. 8 Date of Bi	irth ey, Year) 2,1921	9. Birthplece (Country) GREE	State or Foreign
Usual Residence of Decedent 10a. Stete 10b. County	100	c. City, Town or Lo	cation					side City Limits
MD MONTGOM	ERY	SILV	ER SPRIN	1G			1	Yas 2 No
10e. Sireel and Number			10f. Zip Code			10g. Citizen of \	What Country?	
13104 FOXHALL	DRIVE		20	906		UNITED	STATES	
11. Maritel Stetus 1 Never Married 2 No Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	1	Wes Decedent of f Yes, specify Cul	ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	o- 14. Red	ce - American Ind ck, White, etc.	
15. Decedent's Edi		16a. Deced	lent's Usuel Occu kind of work done	pation	undring	16b. Kind of B	usiness/Industry	
(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	CTRONICS	ed)		ELEC	TRONICS	
17. Fether's Nema (First, Middle, Last) GEORGE KATSAFA	NAS	1 2020	211011200	_	leme (First, Middle	1		
19e. Informant's Neme/Reletionship (T	ype, Print)	19b. Meilin	ng Address (Stree	et and Number or	Rural Route Numb	ber, City or Town,	State, Zip Code	1)
GEORGE C. KATSAF	ANAS/SON	1310	4 FOXHAI	LL DRIVE	SILVER	SPRING,	MARYLAN	20906
20a. Method of Disposition 1) Buriel 2 Cremetion 3 1 4 Donetion 5 Other (Specify,	Removel from State	Ob. Plece of Dispo cemetery, cren AGIA S	netory or other pla	ece)	8/10/99	20c. Location - MEGALOI	City or Town, S	
21. Signature of Funetal Service License	11		Neme end Addr		HINES-RI	NALDI FU	NERAL H	OME, INC.
Hadr- Ju	St.				RE AVE.			
236 Part 1. Enter the diseese, a comp shock, or heart feilure. List only of	lications that caused the one cause on each line.	death. Be not ent	er the mode of dy	ing, such es card	liec or respiretory	errest,	Appr	roximete vel Between et and Deeth
Immediate Cause (Final disease or condition resulting in death)	a	ONAL CELE to (or es a conseq		OF PROS	STATE AND	BLADDER	ONE	YEAR
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	C	to (or as a conseq						
Part II. Other significant conditions co	ntributing to death but not	t resulting in the u	nderlying cause g	iven in Pert I.		i tobacco uee co I Yee 2∭ No	ntribute to the o	
						s en eutopsy formed?	available	utopsy findings e prior to ion of cause ?
					1 🗆	Yes 2 No	1 ☐ Yes	2 No
25. Was case referred to medical				26. Place of I	Death (Check only	one)		
exeminer? 1 Yes 2XXNo	Hospitel:	2 ER/Outpatien	1 3 DOA O	ther: 4 Nursing	Home 5 XRes	idence 6 Oth	ner (Specify)	
27. Manner of Death 1 X Vetural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Yea	28b. Time of Injury	W		The state of the s	how injury occur		
3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (Sp	At home, ferm, str	eet, fectory, office			(Street and Numbown, State)	ber or Rurel Rou	te Number,
29e. Certifier (Check only one) 2 Medical Exami	sician: To the best of my iner: On the basis of exar and manner steted.	knowledge, deeth minetion end/or inv	occurred at the trestigation, in my	ime, date end pla opinion, deeth o	ace, and due to the courred et the time	a cause(s) end me , date end place,	enner es stated. and due to the o	euse(s)
29b. Signalura and title of certifier	i-Nela	lon A.	D. D 23	se number			od (Month, Dey, 1999)	/ear)
30. Neme and address of person who con KEVIN G. NEALON,		(Item 23a) (Type, WISCONS		TE #925	CHEVY CH	HASE, MAR	YLAND	
31. Dete filed (Month, Day, Year)	32. Degistrer's S		Some	1				
JUL 2 9 1999	1	~.	popular.					

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene QQ 25122

		Decedent's Name (First, Middle, Las	()		Certificate of	Death	2. Dete of De	Reg. No.		3. Time of Deet
Physici		Barbara E. Ke	•				July	21 ^{Dey} 19	ğ y r	10:15
/Medic Examir		4e. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or	Location of Death	4c. County	of Deeth	
	Į.	7727 Miller Fa 5. Social Security Number 6. Se		the same to an to take	nday) If Under 1 Yea	Derwood				mery
Funerai Director			M 2D F	(In yrs. last birtl	Months Dey		(Month De	12,37	Count	ece (Stete or Fore hingtor
thow the		10e. Stete 10b. County		10c. City, Town	or Location				10	d. Inside City Lim
State State	cto		gomery	Derwo						XEXYes 2□
23a or 2	Funeral Director	10e. Street end Number 7727 Miller Fa	all Rd.		10f. Zip Code 20855			10g. Citizen of V United		*
hygiena. ther than "natural", or items 23a or 28a-1 show ent, the Medical Examinet must be notified at	by	11. Maritel Status 1 Never Married 20 Married 3 Widowed 4 Divorcad	12. Wes Decedent En Armed Forces? 1 ☐ Yes 2(2)No If Yes, Give Year or Dates:	Little T. I	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ No		Specify Yes or No to Rican, etc.)	- 14. Rec Bled Specify	e - America k, White, e Wh	
an "natur Medical	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16e. I	Decedent's Usuel Occi 'Give kind of work don life. DO NOT use retir	upation	dring	16b. Kind of Business/Industry		
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Il Hygiena. other than rent, the M	Co	17. Fether's Neme (First, Middle, Last)		A	Sales Ass	_	me (First, Middle,			
e v	To Be	Harold Markwa	ard				abeth M		-/	
th and Menta 7 Is marked traumatic or	F	19e. Informent's Neme/Relationship (7)		19b.	Mailing Address (Stree					Code)
		Donald Gold/Hus	sband	7	727 Mille	er Fall	Rd. De:	rwood,	MD.	20855
nent of Haalint: If Item 2		20e. Method of Disposition 1 ☐ Burial 2√□Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify)			Disposition (Name of cremetory or other plant) Opolitian		Dete 7 / 2 3	20c. Location -		
Department Important: It any Injury o		21. Signature of Funerel Service Licens			22. Name end Add	ress of Fecility	Takoma	Funera	al Ho	ome.
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ysician Medicai kaminer		Immediate Cause (Final disease or condition resulting in death)	•	1.1	myelon					Intervel Between Onset end Deeth
nsit	Examiner		b							
g physician and as tha burial-transit	al Exar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events consider the condition of the								
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ata has page 2	E O						101	es 200 No	10	Yes 2□ No
ertific ector,	Be	25. Wes case referred to medical examiner?					oth (Check only o	ne)		
ni di	7	1 ☐ Yes 2 ☑ No 27. Menner of Deeth		-	atient 3L DOA		lome 5 € Resid)
Aftar funai	tion	1 Neturei 5 ☐ Pending	28e. Dete of Injury (Month, Dey	(ear) 28b. Tir	ury We	uryet ork?]Yes 2 ☐ No	280. Describe i	now Injury occurr	ed	
s aftar death. If Director: Aftar this od in by tha funarai d	28e. Plece of Injury - At home, farm						28f. Location (\$ City or Tow	Street and Numbern, State)	er or Aural	Route Number,
unera unera aly fille	edicai (29e. Certifier 1 Certifying Physical Check only one) 2 Madical Exami	sician: To the best of a ner: On the basis of e end menner state	my knowledge, kaminetion end	cath occurred et the ton investigetion, in my	ime, dete end plece opinion, deeth occu	, end due to the or rred at the time,	ceuse(s) end ma dete end plece, e	nner as ste	eted. the ceuse(s)
2 8	M	29b. Signeture and title of certifier	. `		29c. Licen	se number		29d. Date signed	(Month, D	lay, Year)
To the formplat		/4 /4	144							
₹		au)	n mu	ses	DO	7390		July 2	3, 1	999
vithin 2 To the Complete		30. Name and address of person who co	empleted cause of dee	th (Nom) (T	ype, Print)	7390		July 2	3, 1	999

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Grace Evelyn KEENE 07 1999 /Medical 3 9:50AM 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Rensington
Hunder 24 Mrs. 8 Date of Birth
(Month, Day, Year) Montgomery

9. Birthplace (State or Foreign Country) 10414 Parkwood Drive If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2□ F Director 76 3-3-1923 218-20-1903 Maryland Usual Residence of Decedent death with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 10414 Parkwood Drive 20895 United States Funeral 14. Race - American Indian, Biack, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give XX 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: g 3X Widowed 4 □ Divorced white Year or Dates Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) .. Peges 1 end 2 should be filed w tment of Heelth and Mentel Hygien tant: If item 27 is marked other th jury or other traumatic event, the Telephone Operator telephone company 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Trageser Grace (unk.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Donald L. Trageser 1730 Bonifant Road, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 24 Cremetion 3 Removel from Stete permit. Pege Department of Important: If eny Injury or Lincoln Crematory 7-26-99 Dress

22. Name and Address of Facility
Hines-Rinaldi Funeral Home 4 ☐ Donetion 5 ☐ Other (Specify) Ft ture Tuneral Service Licensee Samuel 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel Myocas LOUV disease or condition resulting in deeth) Examiner Examiner Coronari The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): and Box 68760. Physician/Medical the Due to (or es e consequence of) signed by the attending be detached for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20 No 1 ☐ Yes 20 No funeral director. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? After t Netural or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29e. Certifier (Check only one) 200 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38262 12 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

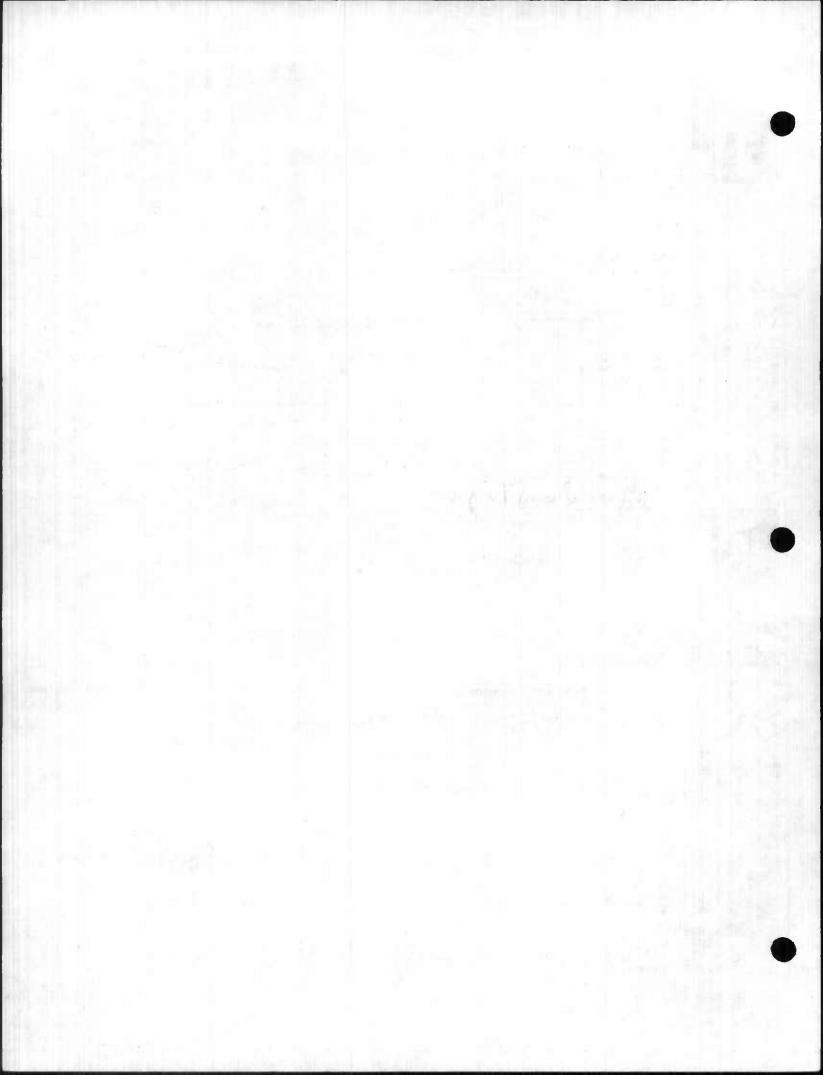
Dr A Mendurata 2401 Res 2401 Research BLUD Suite 340 Rockville mp 31. Dete filed (Month, Day, Year)

JUL 2 6 1999 32. Registrer's Signeture State

Registrar

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 50HM 4e, Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Silver 7. Age (In yrs. lest birthdey) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Montgomery 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 4276 1 M 2 Yrs. 73 Mar.22, 1926 DC Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 7620 Maple Avenue Apt 104 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Clarence Kelley Florence McKinney 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Marr/ Sister 7620 Maple Avenue Apt 104, Takoma Park, MD 20912 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete July 26 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 1999 Alexandria, VA 21 Signature of Funeral Service Licenses 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, shock, or heart leilure. List only one ceuse on each line. MD 20901 Approximate Interval Between Onset end Deeth Von Small Cell Carchema Immediate Cause (Finel diseese or condition resulting in deeth) -Imenan Obstrative 210210 Due to (or es e consequenca of): en sion 9 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 XYss 2 No 3 Probably 4 Unknown Moker 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? nemia ecubilus 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 28. Piece of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Waturei 5 Pending 1 ☐ Yes 2 No Investigation 2 Accident

Physician /Medical Examiner buriel-transit certificata be executed and

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signed by the a

has

i or Attanding Physician: after death. Director: After this certific

To the Hospital or Atta within 24 hours after de To the Funeral Directo complataly filled in by th

funeral

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Completed

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Certification:

Medical

Dapartment of Important: If

Physician

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Funeral

Director

Fig. 1 and 2 should be filed within 72 hours after death with the Maryland set of Health and Mental Hyglene.

WILL II then 27 is marked orther than "naturar", or items 23e or 28e-f ahow may or other trannal to notified a

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at

Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Physician/Medical

1 Yes 20 No

3 Suicide

29e. Certifier

4 Homicide

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner steted. 29b. Signeture and title of certifier

29d. Dete signed (Month, Dey, Year) 29c. License number

30. Name and eddi s of person who completed ceuse of deeth (Item 23a) (Type, Print) 29 60 100

165 WD 000 ceredution

State Registrar

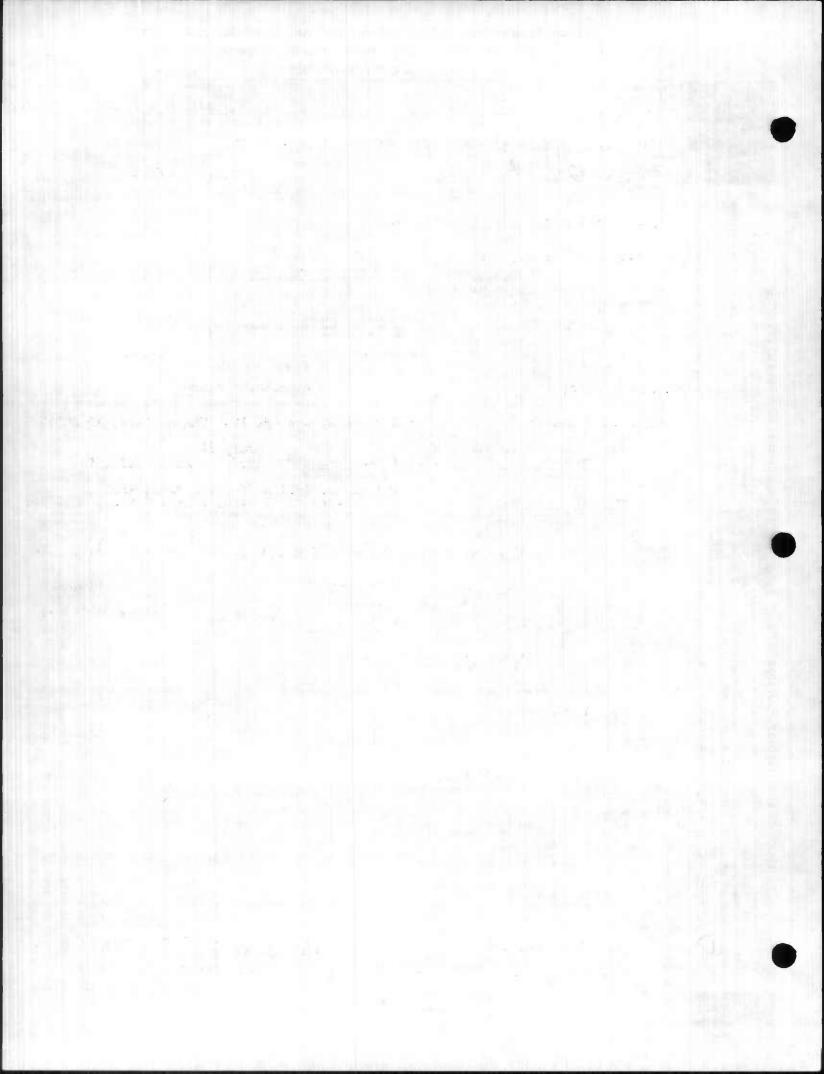
1 31. Dete filed (Month, Dey, Year) 2 1999 7 JUL

6 Could not be determined

32. Registrar's Signeture

1-011

A Cortifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.



State of Maryland / Department of Health and Mental Hygiene QQ 25126

		Certificate of		Reg. No.	20100					
Dhusisian	Decedent's Name (First, Middle, Last)			ate of Death fonth Day	3. Time of Death					
Physician /Medical	Virginia W.Kibler		J	uly 22, 1999	2:15 P					
Examiner	4a Facility Name (If not institution, give street and number)		4b. City, Town, or Location							
<u> </u>	13211 Ewood Ln		Silver Spri		gomery					
Funeral Director	5. Social Security Number 218-30-4248 6. Sex 1 M 2 F 7. Age	91 Yrs. Months De	ear If Under 24 Hrs. 8. p. ys Hours Min. Ma	ate of Birth fonth, Day, Year) y 23, 1908	9. Birthplace (State or Foreign Country) Virginia					
show show stat	10s. State 10b. County	10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☒ No					
viin the Ma or 28e-f a be notified	Maryland Montgomery 10e. Street and Number	Silver Spring		10g. Citizen of						
	13211 Ewood Ln	20	906	USA						
	11. Marital Statua 1 Never Married 2 Married 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:	o 1 Yes 2 Z	of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ricar No Specify:	(es or No- i, etc.) 14. Rac Blai	pe-American Indian, ck, White, etc. White					
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Mental Hygiene. This marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-	life. DO NOT use re	one during most of working		usiness/Industry					
D D D D D D D D D D D D D D D D D D D	17. Father's Name (First, Middle, Last)	Hallager	18. Mother's Neme (Firs	t, Middle, Maiden Suman						
yland bould be it Mental H arked off atto ever	Harry A. Bestpitch		Fanny S. L	ewis	·					
Mary San Mar	19a. Informant's Name/Relationship (Type, Print)		reet and Number or Rural Roo		State, Zip Code)					
	Robert E. Kibler/Son 20m. Method of Disposition	20b. Place of Disposition (Name of	ers Rd, Vienn		- City or Town, Stete					
altimore mit. Pages 1 partment of Hy portant: it les y injury or oth	1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)	Union Cemetery	place)		nsville, MD					
Halt mmit. sparts sylish sparts sylish sparts sylish sparts sparts sylish sylish sparts sylish sylish sparts sylish sylis	21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funera									
m 89728	Dlang. Donne	ll 11800 Ne	w Hampshire A	ve, Silver S	Spring, MD 20904					
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	gest ve He Due to (or as a consequence of):	and F	arline	several					
68760, filicate be executed to physician and as the burlet-transit Addical Examiner	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):								
D = 5	that initiated events resulting in death) Last	Due to (or as e consequence of):								
Seath cert attending of for use	Part It. Other significant conditions contributing to death but	t not reculting in the underkring equal	airm in Part I	22h Did tohacea usa co	intribute to the cause of death?					
ords, P.O. Box requires that the death cent requires that the death cent seen signed by the attending hould be deteched for use sted by Physician/N	Part II. Other arginizant continuous contributing to death bu	t not resulting in the uncertying couse	gwen in Parti.	1 □ Yes 2 (No	3 Probably 4 Unknown					
0 - 0 0 =				24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?					
The lew ate has page 2				1 ☐ Yes 20 No	1 ☐ Yes 2 ☐ No					
r Vital F ysician: The s certificate director, peg	25. Was case referred to medical axaminer?		26. Place of Death (Ch	eck only one)						
- 5 . 5 E	1 ☐ Yes 202 No Hospital: 1 ☐ Inpatier	1 2 ER/Outpatient 3 DOA		52 Residence 6 □Ott	ver (Specify)					
Vision of Attending Process. After the funeral iffication:	27. Manner of Death 12 Natural 5 Pending (Month, Day) 2 Accident investigation		njury at Work? 28d. (Describe how injury occur	red					
DIVISION OF To the Mospital or Attending Phy within 24 hours after deeth. To the Funestal Director: After thi completely filled in by the funestal Medical Certification: 7	4 Homicide building, etc.			City or Town, State)	ber or Rural Route Number,					
ne Hospi n 24 hou ne Funer pletely till adical	29a. Certifier (Check only one) Certifying Physician: To the best of a Medical Examiner: On the basis of and manner stet	examination and/or investigation, in n	e time, date and place, and d ny opinion, death occurred at	ue to the cause(s) and m the time, date and place,	anner as stated. and due to the cause(s)					
Within 2 To the comple	29b. Signature and title of certifier	A .	ense number	29d. Date signe	ed (Month, Day, Year)					
5	Hand Cromin	uy)	13835	July.	23,1999					
	30. Name and address of person who completed cause of de David Cromwell 831 Univ	ath (Item 23a) (Type, Print) versity Blvd, Eas	t, Suite 37,	Silver Spri	ng, MD 20903					
State	31. Date filed (Marth, Day, Year) 32 Registra	r'a Signature	1,							

DHMH 16 Rev 6/95

X

Manager

Harry A. Bestpitch

Robert E. Kibler/Son

Fanny S. Lewis

10721 Lawyers Rd, Vienna, VA 22,

Union Cemetery

Jul 26 Burto Hines-Rinaldi Fun

11800 New Hampshire Ave, Silver Sp.

Demo

de laarre 'aak altusdam man 00011

Congestive Heart Failure

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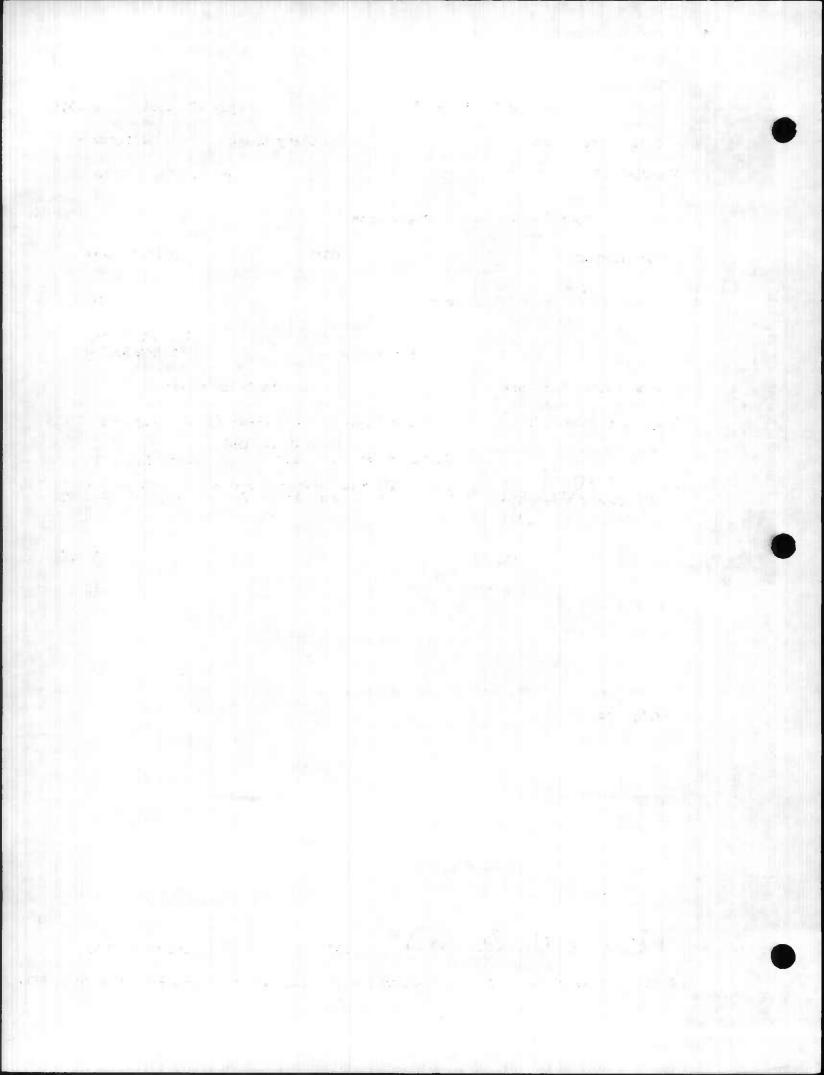
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lver Spr:

State of Maryland / Department of Health and Mental Hygiene 9 25 1 3 7

					Cei	rtificate of	Death			Reg. No.		
		1. Decedent's Neme (First, Middle	, Last)						2. Dete of De Month	Dey	Yeer	3. Time of Deeth
	Physician (Martina)		John Junio	or Kira	cofe					2, 1999	1001	15:45
	/Medical Examiner	de Casilla Stema //frantinglication	give street end nur	m <i>ber</i>)			4b. City, To	wn, or Lo	ocation of Deet	h 4c. Count	y of Deeth	
	LAGITITICS	3116 Winnett	Road				Chevy	z Cha	ase	Mo	ntgom	erv
	Funeral	5. Sociel Security Number	6. Sex	7. Age (In yrs.	lest birthday)	If Under 1 Yee	r If Under	24 Hrs.	8. Dale of Bir	th		oleca (Stete or Foreign
	Funeral Director	578-38-2214	1⊠M 2□F	92	Yrs.	Months Deys	Hours	Min.	(Month, De	6, 1907 Ohio		
		Usuel Residence of Decedent	Usuel Residence of Decedent									
	Mand Mand	10e. Stete 10b. County	10e. Stete 10b. County 10c. City, Town or Location									Od. Inside City Limits
	Men in the part of	Maryland Mont	gomery		Chevy	Chase						1 ☐ Yes 2 🖾 No
	or 28a-f slow noutled	10e. Street and Number	8			10f. Zip Code				10g. Citizen of	What Cour	ntry?
						208	15			Unite	d Sta	tes
	fler death with the result of	3116 Winnett	12 Was Dans	edent Ever in U.	S 13 1			ain? (Sp	ecify Ves or No		ca - Americ	
	Per de la composition della co	1 Never Married 2 Merri	Armed Fo	rces?	,3.	Wes Decedent of If Yes, specify Cu	ban, Mexicar	, Puerto	Rican, etc.)	Ble	ck, White,	
70	by F		ff Yes, Giv	/8	тт	1□Yes 2XN	Specify:			Specia	b: Wh	ite
3	"natural",	3 Vildowed 4 Divorced	Yeer or D	ates: WW		1				16b. Kind of B		
Maryland 21215-0020	ed within 72 hor ygiene. Ygiene. Ar the Material Completed	15. Decedent (Specify only highes	s Education t grade completed)		(Give	dent's Usuel Occi kind of work don DO NOT use retir	apation e during mos	t of work	ing	The second		
N	withir ene.	Elementery/Secondery (0-12)	College (1	-4or 5+)			60)			United		es
Z	e filed within at Hygiene. other than vent, to M		4		Acco	untant	10 Math	ula Atam	n (Class Adiabatio	Govern		
Ĭ	be filed d other event,	17. Fether's Neme (First, Middle, I								, Maiden Sumei	110)	
Ž		•							Belle M	-		
O	s tend 2 should f Health and Mer tem 27 is marks other traumatic	19e. Informent's Name/Reletionsh				ng Address (Street						
	other tr	Mary S. Kiracof	e/Wife			Winnett	Road,	Che	evy Cha	se, Mar	yland	20815
o e	of He	20e. Method of Disposition 1	• 		Place of Dispo emetery, crea	sition (Neme of metory or other p	ece) July	26	1999°	20c. Location	- City or To	own, Stete
Ĕ	Pages nent of I int: If Ite	4 Donetion 5 Other (Sp		Pa	rklawn	Memoria	1 Parl	k i		Rockvil	lle. N	Maryland
Baltimore,	permit. Pag Depertment Important: Il any Injury o	(21. Signature of Funeral Semice I	icersee	1	_22	2. Neme end Add	ress of Feciti	ty_				
Ď	Ped Jany	Mill X	Logian	M008	46 Ro	bert A. P 57 Wiscon	umphrey	Fune	ral Home Bethesda	/Bethesda	-Chevy	Chase, Inc
-		23e. Part1. Enfer the diseese, or ehock, or heart feilure. List	complications thet c	aused the deat							200	Approximete
	Dh	ehock, or heart feilure. List	only on a state on e	ech line.								Intervel Between Onset end Deeth
A	Physician	Immediate Cause (Final									1	
	Examiner	diseese or condition resulting in death)	e Arry	thmia								Immediate
				Due to (c	r es e conse	quence of):						
Т	per les		b. Coron	nary Ar	tery D	isease					- 1	15 Years
_	entificate be executed ding physician and se es the bunal-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		Due to (o	r es e consec	quenca of):					i	
68/60,	be e ician bunic	cause. Enter Underlying Ceuse (Diseese or Injury	c								1	
œ	flicate be physicia as the bur	resulting in deeth) Last		Due to (o	r es e consec	juence of):					1	
×	Jing Jing	1	d								1	
200	ath of the or union or union										1	
	0 0 0	Pert II. Other significant conditio	ns contributing to de	eath but not res	uiting In the u	nderlying ceuse (iven to Pert	t.	23b. Did	tobacco use co	ontribute t	o the cause of death
Ţ.	requires that the een signed by the hould be deteched by Physelect By	Emphysema							1 💢	Yes 2 No	3 Pro	bably 4 Unknow
Ś	bed by	2 Empiry Scina					-				1	
Hecord	The law require sate has been signate has been signate page 2 should be Completed									en eutopsy ormed?	94	ere autopsy findings
ပ္သ	law release be 2 sh											deeth?
ř	The law								10	Yes 210 No	11	☐ Yes 2☐ No
VItal	ician: The certificate rector, pag	25. Wes case referred to medical					26 Place	of Deet	th (Check only	one)	1	
>	Physician: this certific ral director, To Be	exeminer?	Hospital:	Inpatient 2 🗆	ER/Outpaties	ni 3 DOA	Mb. co.			idence 6 □Ot	her (Sneci	(h/)
Ö	Phy ral d		28e. Dete	of fnjury	28b. Time o				And the second	how injury occu		.,,,
DIVISION	Attending or death. Sctor: After by the fune liftcation	1 XNaturel 5 Pending	(Mon	th, Dey Year)	Injury		'ork? ⊒Yes 2.□	No				
S	Attendi er death. ector: A by the fi	2 Accident Investig	ot be	of laiun, - At h	ome ferm st	reet, fectory, offic			28f. Location	Street end Num	ber or Run	el Route Number,
≥		4 ☐ Homicide determi	ned buildi	ng, etc. (Specif	y)	eot, rectory, onto				wn, Stete)		
_	Prai Surs		Dhualden T- th-	hant of mulino	viladas dasti	h accurred at the	time data as	d along	and due to the	enuna(a) and m		stated
	n 24 hour n 24 hour ne Funer pletely fil	29a. Certifier 12 Certifying (Check only one)	Physician: To the examiner: On the back	asis of examina								
	To the Hospital or within 24 hours efter a vithin 24 hours efter To the Funeral Dir completely filled in Medical Cert		ena men	ner steted.		29c Lice	nse number		T	29d. Dete sign	ed (Month	Day, Year)
		Egg. ordinater a arrest trice of per trice.	11000	BA I	1.1							
	8+1	Keen a.	Neal	ext W	((1)	D231	27			July 2	3, 19	99
		30. Neme end eddress of person										
		Kevin G. Nealor				n Avenue	#925,	, Che	evy Cha	se, Mar	yland	20815-4330
	State	31. Dete filed (Month, Dey, Year)		legister's Signe	eture	4 1	11					
	Registrar	JUL 2	1999	Corper	1	1. 1900	uco/					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene	9	-	0)
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	•	Si	ate of Maryland		partment of F ertificate of		and M	ental Hy	/giene	כנ	23	130
Dhyalaia		1. Decedent's Name (First, Middle, Last)						2. Date of D	eath Day	Year		ime of Death
Physicia /Medic		HELEN KIRBY						JULY 2	22 19			:45 pm
Examine	er	4a. Facility Name (If not institution, give stree	and number)			4b. City, To	wn, or Lo	cation of Dear	th 4c. Co	ounty of Dea	ath	
		STELLA MARIS 5. Social Security Number 6. Sex	7 Ann /in um in	at hilathair		TIMO!		0. Data of Di		TIMO		
Funerai Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. ia	st birtnae Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, D		C	ountry)	State or Foreign
Director	1	Usual Residence of Decedent	85					AUG. 2	24 19	LJ MA	ARYL	AND
how	.	10a. State 10b. County	10c. City,								10d. Ins	side City Limits
diffe	cto	MARYLAND ANNE ARU	NDEL ANNA	APOI	LIS						1 [Yes 2 No
or 21	Directo	10e. Street and Number	######################################		10f. Zip Code					n of What C	ountry?	
r 23a Dust.			TERRACE		2140				U			
	/ Funerai	1 ☐ Never Married 2 ☐ Married 1	/as Decedent Ever In U,S rmed Forces? ☐ Yes 2 N No Yes, Give	. 1	 Was Decedent of F If Yes, specify Cubin 1 ☐ Yes 2√2 No 	lispanic Orlan, Mexicar Specify:	gin? (Spe i, Puerto I	city Yes or N Rican, etc.)		Black, Whi		ian,
urer.	d by	3 XWidowed 4 □ Divorced Y	ear or Dates:		41					BLA		
e. an "nat Medica	Completed	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12)		(Gi	cadent's Usual Occupive kind of work done b. DO NOT use retired	during most	t of workli	ng	16b. Kind	of Business	s/Industry	
ent of Health and Mental Hygiene. It, if Hem 27 is marked other than ry or other traumatic event, tha I	ဝိ	11th o	E	ENVI	RONMENT	SERV			A.A.		ERAL	HOSPIT
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nd Me mark matic	ဌ	19e. Informant's Name/Relationship (Type, F	riot1	10h Ma	ailing Address (Street			Boute Numb		own State	Zin Code	1
of the action of			UGHTER)		CHESAPE						,	
H H H	Ì	20a. Method of Disposition	COL	ce of Dis	sposition (Neme of remetory or other place		DI	Date		tlon - City or		
Ty or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State		IS MEM.		FNC	7/27/	99 71	אזאזא דאר	TTC	MD
Nepartm mports any Inju	Ì	21. Signature of Funeral Service Licensee	111112	11 01	22. Name and Addre	ss of Facilit	у	11611	22 A	MINAT	ים דם	, IND.
25 5 8	S	Larry J. Aco	40		WM. REES	E &	SONS	MORT	UARY	, P.F	4.	
		23a. Part1. Enter the disease, or complication shock, or heart fellure. List only one ca	ns that caused the death.	Do not e	enter the mode of dyli	ng, such as	cardiac	APOLY	Sat, MI). 21	4 Q 1	oximate val Between
nysician Medical											Onse	t and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) LUNG CANCER											
	ē		Due to (or	es e cons	sequence of):						1	
nansit	Examiner	Sequentially list conditions b	Due to for a	as a cons	sequence of):						1	
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
physician end s the bunel-transit	edicai	Cause (Disease or injury that initiated events resulting In death) Last	Due to (or a	s a cons	sequence of):						†	
00		d										
for us	sician/M										1	
y the	Physi	Part fl. Other significant conditions contribut	ing to death but not result	ing in the	underlying cause giv	en in Part I						ause of death?
ned b a dete	by P							11	Yes 2	No 3∐1	Probably	4X Unknown
2 should	Completed								s an autopsy ormed?	24b.	availeble	on of cause
page	5							10	Yes 2X	Vo	1 🗆 Yes	2□ No
s certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?	-1.		I au		of Death	(Check only	one)			
al din	ို	1 Yes 2 No Hospit	1 Inpatient 2 LE			4LI NU		ne 5□Res			ecity) H(OSPICE
After funer	ation:	1 Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year)	28b. Time Injur	y Wo	yat rk? Yes 2 □ I		8d. Describe	now injury o	ccurred		
deatl ctor: y the	lica	3 Suicide 6 Could not be 28	e. Plece of Injury - At hom	ne. farm.		100 2		8f. Location	(Street and h	vumber or F	Rural Route	e Number.
i Dire	Certific	4 Homicide	building, efc. (Specify)		,				wn, Stete)			
	edicai	29a. Certifier (Check only one) 1 Certifying Physician Certifying Physi	: To the best of my knowl on the basis of exemination	edge, de on and/or	eth occurred at the tir Investigation, in my o	me, date an pinion, dea	d place, a th occurre	nd due to the	cause(s) an date and pl	d manner e ace, and du	es stated.	Buse(s)
Mithin To the	Σ	29b. Signature and title of certified			29c. Licens	e number			29d. Date s	igned (Mon	nth, Dey, Y	'ear)
		147			DU	1372	5		71	231	99	
		30. Name end eddress of person who complete	ed cause of deeth (Item 2	23e) (Typ	e, Print)						-	
		DR. TARIQ MAHMOOD 2			EY RD. T	IMONI	UM, N	D 2109	3			
State Registra	-	31. Dete filed (Month, Day, Year) JUL 2 8 1999	32. Registrar's Signetu	re	6. Som	41						

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6:45 р.ш.

July 22, 1999

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

11 68 4.000 North

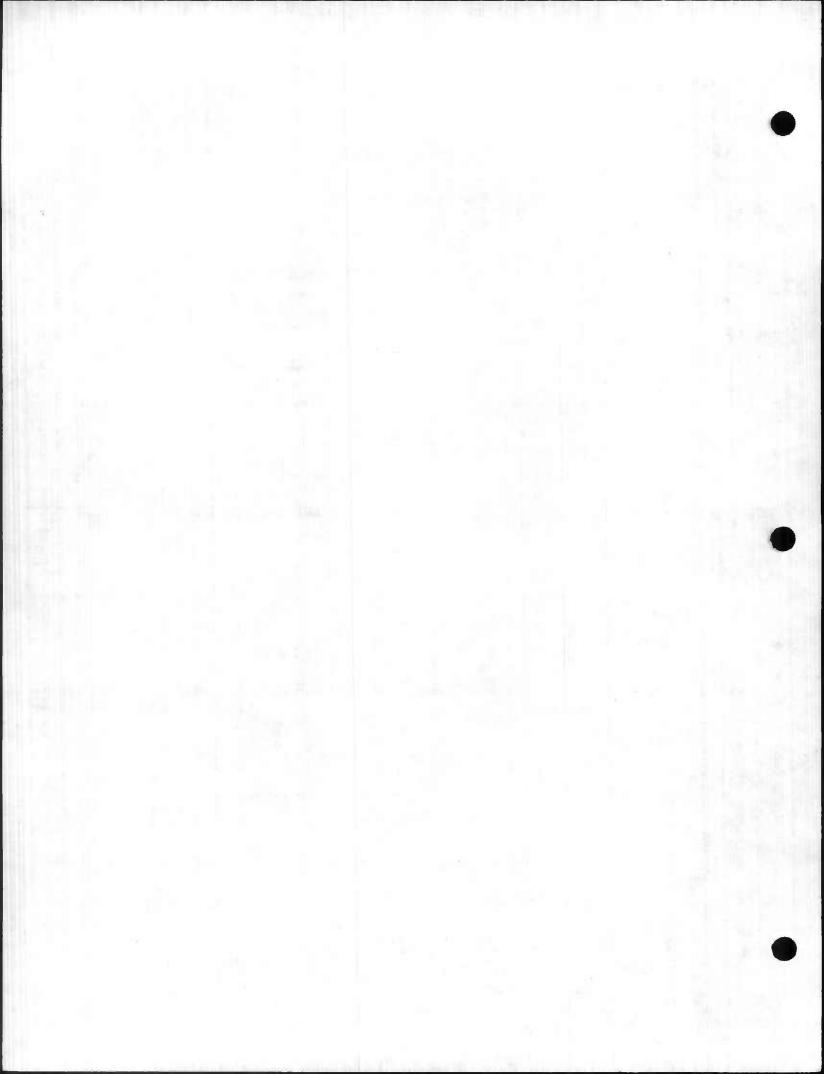
State of Maryland / Department of Health and Mental Hygiene 99 25139

	Decedant's Nama (First, Middla, La.	•				2. Date of De	eath Day	3. Time of Death
Physician /Medical	Catherine M.	. Knodt				July	24, 19	8:00 am
Examiner	4a Facility Nama (If not institution, give	a street and number)				r Location of Deat		
	Homeplace Est			day) If Under 1 Y	Glen B	urnie		Arundel
Funeral Director	5. Social Security Number 6. S 217-40-3030 1	ox 7. Aga (n □M 2√2 F	94 Y	Months D	ays Hours Mir		1, 1905	Birthplace (Stata or Foreign Country) Maryland
a or 28a-f show the notified at Director	10a. Stata 10b. County		c. City, Town					10d. Inside City Limits
28a-f show notified at	MD Anne	Arundel (Glen E	urnie				1 □ Yas 2√2 No
r Nems 23s or 28s-ferins instrument be notified Funeral Director	101 Sandsbury	Avenue		10f. Zip Co 2106			10g. Citizen of W JSA	That Country?
b V	11. Marital Status 1 □ Nevar Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2X No If Yas, Giva Yaar or Datas:	r in U,S.	- Control of the	of Hispanic Origin? (Cuban, Mexican, Pus No Specify:	Specify Yas or No irto Rican, etc.)	14. Race Black Specify:	- American Indian, k, Whita, atc. White
	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)				ccupation one during most of w stired)	orking	16b. Kind of Bus	siness/industry
Hygiene. ther than ent, me	8			Homemake			Home	
Be very	17. Fathar's Nama (First, Middla, Last) Henry Klasmed						, Maiden Surnama	a)
marked committees	-		1			Fritz		0
27 le	19a. Informant's Name/Raiationship (Barbara A. (Quillen/Ni	Lece10	Marbury			Park, MD	21146
ent of Healt m: If item 2 ry or other	20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Ramoval from Stata	cematery	Disposition (Nama of crematory or other	place)	July 26	Baltimo	City or Town, Stata Dre, MD
Physician and straight and stra	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inhisted events	b. Dur	e to (or as a co	risequence of):	R ACCI	DEN		110014-3
170.00	resulting in death) Last	d	10 (0. 03 0 00	nacedara are sub-				
the attached for a	Part II. Other significant conditions of	ontributing to death but n	ot resulting in	he underlying caus	e given in Part I.	23b. Did	tobacco use con	tribute to the cause of death
signed by the defeather designed by Physical design						10	Yes 2□ No	3 Probably 4 Unknow
shoul lete							an autopsy omed?	24b. Were autopsy findings available prior to completion of cause of death?
12 (N DL						10	Yes 250 No	1 Yes 2000
e has age 2 omp					me 200	eath (Check only	one)	
tificate ha tor, page the Com	25. Was case referred to medical				26. Place of D			Anninka
his certific if director To Be	examiner? 1 Yes 2 No 27. Manper of Death		2 ☐ EPVOutp	ne of 28c.	Other: 4 Nursing	Home 5 Bes	idence 6 ØOthe how injury occum	
his certific if director To Be	examiner? 1 Yes 2 No 27. Mariper of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Vi	28b. Ta	ne of 28c. ury M	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 Describe 28d Describe 28f Location (how injury occum	
er death. settor: After this certificty the funeral director	examiner? 1 Yes 2 No 27. Manner of Death 1 Manual 5 Pending 2 Accident investigator	28a. Date of Injury (Month, Day Ye	28b. Ta	me of 25c. ury M	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 Describe 28d Describe 28f Location (how injury occum	nd g
w hours after death. Funeral Director: After this certification by the funeral director ledy filled in by the funeral director lical Certification: To Be	examiner? 1 Yes 2 No 27. Mariner of Death 1 Natural 2 Accident investigation 3 Suicide 4 Homicide 29a. Cartifier 1 Cartifying Ph	28a. Date of Injury (Month, Day Vi	At home, tan specify) y knowledge, amination and	me of 28c. M n, street, factory, of death occurred at the	Other: 4 Nursing Injury at Work? 1 Yes 2 No.	28d. Describe 28d. Location (City or You	(Street and Number, State) cause(s) and ma	er or Rural Route Number,
er death. settor: After this certificty the funeral director	examiner? 1 Yes 2 No 27. Manner of Death 1 Manual 5 Pending investigation 3 Suicide 6 Gould not be determined. 29a. Certifier (Check only 2 Medical Exam	28a. Date of Injury (Month. Day V.) 28a. Place of Injury building, etc. (3 yalcian: To the best of maner: On the basis of ex-	At home, tan specify) y knowledge, amination and	me of ury M 28c. M, street, factory, of death occurred at the or investigation, in	Other: 4 Nursing Injury at Work? 1 Yes 2 No.	28d. Describe 28d. Location (City or You	flow injury occurs (Street and Numbi wen, State) cause(s) and ma date and place, a	er or Flural Floute Number,

State of Maryland / Department of Health and Mental Hygiene 9 9 25 | 4 0

_	1. Decedent's Name (First, Middle, Last)			rtificate of	Douth	2. Date of Deat		3. Time of Death	
Physician	YONG JUL	LEE				JULY 2	Day 6. 1999	Yeer 6.00 AM	
/Medical Examiner	4e Facility Neme (If not Institution, give s				4b. City, Town, or L		4c. County o	6:00 AM	
Examiner	MANOR CARE NURSIN	G HOME			SILVER	SPRING	MON	TGOMERY	
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, JUN 11,	Year)	Birthplace (State or Foreign Country) KOREA	
Du Bu	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits	
the Maryland 25a-4 show sottlifed.at	MARYLAND MONTGOM	ERY (GAITHER	SBURG				1 ☐ Yes 2 No	
vim the Ma t or 28e-f s be notified Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of WI	hat Country?	
P will	18525 BOYSENBERRY	DR		208	79		USA		
20 atter death with the Maryle or Herm 23e or 23e-f sho trifet must be notified at f Funeral Director	1 Never Merried 2 Married	I2. Wes Decedent Ever in I Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give		Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, c, White, atc.	
0 5 5 6	3 Widowed 4 Divorced	Yeer or Dates:		100 200110	opeany.		эрвспу.	ASIAN	
i Z1Z15-UUZU ed within 72 hours atter ygjere. ar then 'netures', or its it, the Medical Exemple Completed by Fu	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of work	ing	16b. Kind of Business/Industry		
N pale N	47 Fethada Nama (First Middle Leat)		H	OMEMAKER	18. Mother's Nem	o /Final Adidate A		HOME	
E 2355 0	17. Father's Neme (First, Middle, Last) UNOBTAINABLE				UNOBTAI		naiden Sumerne	9	
Brylis and Mer and Mer america aurmetic	19a. Informent's Name/Relationship (Ty)	pe, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Number	City or Town, S	State, Zip Code)	
2 TH M L	KRIS H. LEE/SON		185	25 BOYSE	NBERRY DR	, GAITHE	RSBURG,	MD 20879	
os 1 and of Health Them 27 r other tr	20a. Method of Disposition		Plece of Dispo	sition (Name of metory or other ple				City or Town, State	
Pages nent of unt: if la	1 Burial 2 Cremetion 3 R 4 Donation 5 Other (Specify)		FAIRFAX	MEMORIA	L PARK	JUL 28	FAIRFA	X, VA	
Sattimore, semit Pages 1 ar Separtment of Hea myortant: if Hem 3 my Injury or othe MGB.	21. Signature of Funeral Service License	0.0	22	2. Name and Addre	ess of Facility HI		LDI FUN	ERAL HOME	
n garage) Olan	Donnell	1	1800 NEW	HAMPSHIR	E AVE, S	ILVER S	PRING, MD 2090	
Physician .	23a. Pert1. Enter the disease, or complications, or heart lailure. List only on	cations thet caused the dea e ceuse on each line.	ath. Do not ent	er the mode of dyi	ng, such es cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
/Medical	Immediata Causa (Final disease or condition CEREBRAL BLEEDING								
Examiner	disease or condition resulting in deeth) Due to (or as a consequence of):								
je le		D0e 10 ((or as a consec	(uerica oi):					
D6 / DU, ificate be executed physician and as the burial-transit edical Examiner	Sequentially list conditions	Due to (or as a consec	puence of):					
Exa Exa	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,					
ficate be expensed in the burial Edical E	Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):					
# D # _	resulting In death) Last								
eath certific attending of for use as	- d								
the des	Part II. Other eignificant conditions con	tributing to death but not re	sulting in the u	nderlying cause gi	ven in Part I.	23b. Did to	bacco use cont	tribute to the cause of death?	
s that the death cert ned by the attendin e detached for use by Physician/M	HYPERT	ENSION				1 🗆 Ye	2 No	3 Probably 4 Unknown	
orvision of vital records, F.O. box or Attending Physician: The lew requires that the death cert after clearly. Bristian has been signed by the attending in by the funeral director, page 2 should be detached for use ertification: To Be Completed by Physician/Nertification: To Be Completed by Physician/Nertification.						24a. Was e perform	n autopsy ned?	24b. Were autopsy lindings available prior to completion of cause of death?	
The lever the le						1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No	
yeiclen: The li yeiclen: The li s certificate he director, page	25. Was case referred to medical				26. Place of Deel		Λ		
Physician: rthis certific and director,	examiner? 1 Yes 2 No	ospitel:	ER/Outpatier	nt 3 DOA Ot	her	me 5 Reside		r (Specify)	
ding Physical distributions of the control of the c	27. Manner of Death	28a. Dete of Injury	28b. Time of			28d. Describe ho			
atto	1 Neturel 5 Panding 2 Accident investigation	(Month, Dey Year)	Injury		Yes 2 No				
bal or Attending P is after death. al Director: After ided in by the funeric Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Speci		reet, factory, office		28l. Location (St. City or Town		er or Rural Route Number,	
To the Hospital or / within 24 hours after To the Funeral Dire completely filled in the Medical Certi	29a. Certifier (Check only one) 1 Certifying Phye 2 Medical Examin	ician: To the best of my kn er: On the basis of examin-	owledge, death etion and/or in	n occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, da	use(s) and man ate and pieca, ar	iner as stated. ind due to the cause(s)	
Med Med	29b. Signature and title of cartifier	and manner stated.		29c, Licens	se number	2	9d. Date sinned	(Month, Dey, Year)	
F.¥ ₽.8		1,100	MIL	2			JULY 26		
	1001	00 17		230	941		JULI ZO	, 1777	
	30. Name and address of person who come OKI KWON 110				PRING, MD	20910			
State	31. Dete liled (Month, Dey, Year)	32 Registrar's Sign	nature 4	Sparks	/				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 25 | 4 | State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Long M 12:45 Pin James 11999 27 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 24 Hrs. 8. (MONTGOME RY 8. Date of Birth (Month, Day, Year) MAY 11,1941 7. Age (In yrs. lest birthday) If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 X M 2 ☐ F Days Hours Min. GEORGIA 58 261 56 2224 Usual Residence of Deceden 10c. City, Town or Location 10b. County 10d. Inside City Limits MONTGOMERY GAITHERSBURG 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 25024 DUNTERRY COURT UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1960 – 1 M Yes 2 □ No If Yes, Give Year or Dates: Raca - American Indian, Bleck, White, etc. Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 25 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) COMPUTER SYSTEMS ANALYST 12 18 Mother's Name (First Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) BERTHA PRINCE WILBURN CARTER LONG 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) 784 QUINCE ORCHARD RD. #202, GAITHERSBURG, MD. 20878 BONNIE S. LONG, WIFE 20b. Placa of Disposition (Neme of cametery, cremetory or other piaca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 7/28/99 ALEXANDRIA, VA. 5 □ Other (Special) 4 Donation 21, Signature of Funeral Service Licer MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final Branchesenic 14 d disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

that the death certificate be executed

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I or Attanding Physician: after death. Director: After this certific

24 hours a Hospital

To the Hose within 24 ho To the Fune completely fi

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P.O. Box 68760

Division of Vital Records,

Physician

/Medical

Examiner

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Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or itema 23a or 28a-f shot traumatic event, the Medical Exactings must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Example once.

Baltimore, Maryland 21215-0020

with the Maryland

death

Examiner physician and s the burial-trans Physician/Medical 88 950 þ Completed

Be

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Certification:

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes ≥ No 27. Menner of Death

5 Pending Investigation 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Nnpetient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated.

maryland

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Netural

2 Accident

3 Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated. 29b. Signeture end title of certified MD

29c. License number 047791 29d. Date signed (Month, Dey, Year)

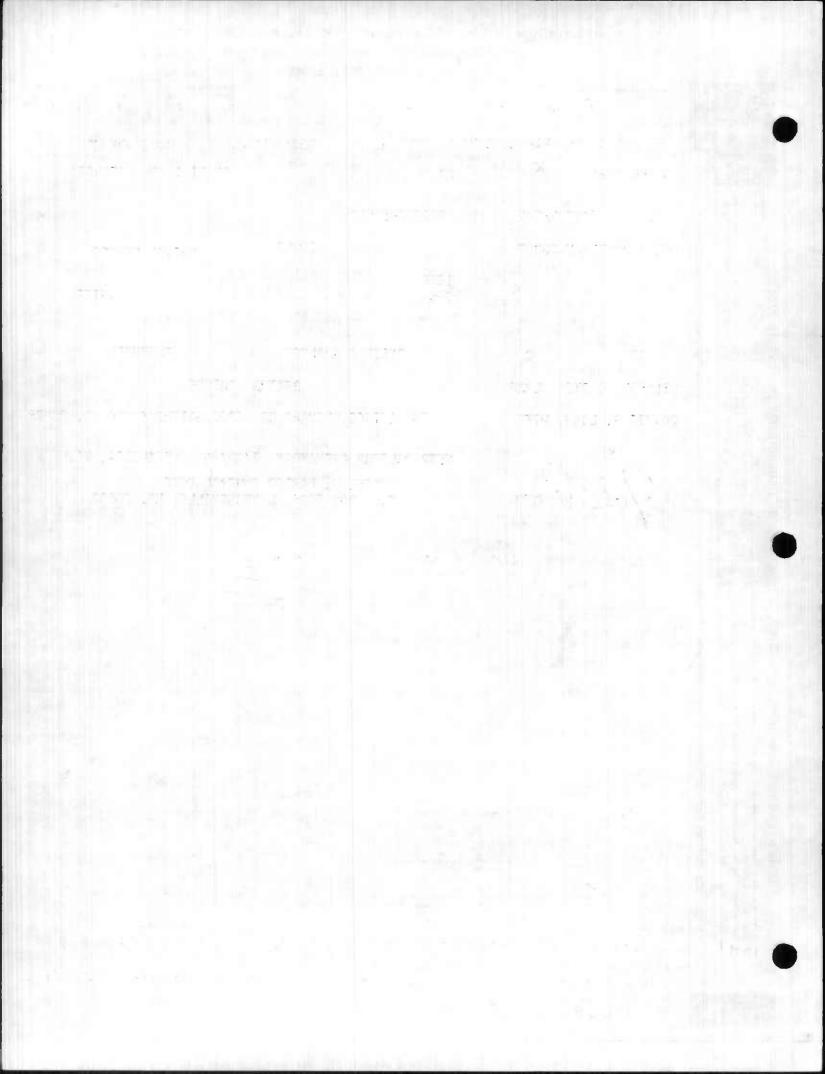
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 809 Veirs mill Rd, Rockville. David A Holden mD

31. Date filed (Month, Dey, Year)

JUL 2 9 1999

32. Registrer's Signeture

State



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month 07.21.1999 9:48 AM SONYA F. LUGER 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) 4c. County of Death MONTGOMERY BETHESDA SUBURBAN HOSPITAL Birthplace (State or Foreign Country) If Under 24 Hrs If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Days Months Hours 1 M 2 XF 82 Yrs. ESTONIA 099-09-9313 03.09.1917 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1⊠Yas 2□No MONTGOMERY ROCKVILLE MD 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zin Code 20852 263 CONGRESSIONAL LANE #413 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 12. Wes Decedent Ever In U.S. 11. Meritel Stetus Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: Biack, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No Specify: 3 ₩idowed 4 Divorced WHITE 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) OWN HOME HOMEMAKER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DINA KIRSCHNER SAMUEL SROELOV 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 10331 WATKINS MILL DRIVE, MONTGOMERY VILLAGE 0886 SAMUEL R. BLATE/SON 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State MAUSELLEUM Parklawn Cemetery 7.26.99 Rockwill 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23e. Pert1. Enter the disease or combilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset end Death fmmedlete Cause (Final diseese or condition resulting in death) Brain cardiovascular disease VOTIC Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show.

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flams 23a

"natural", or

Hygiene.

h and Mental 9 7 is marked of Pages 1 and 2 should be

Department of Health a Important: if Item 27 is any injury or other tra

72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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Examiner Physician/Medicai by

physician and s the burial-trans Completed Be 0 Certification:

25. Was case referred to medical examiner?

1 ☐ Yes No

27. Menner of Death Netural 5 Pending Investigation 2 Accident 6 Could not be

29b. Signature and file of certifie

3 Suicide 4 Homicide

Inpatient 28e. Dete of Injury (Month, Dey Year)

Hospitel?

Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 □ Yes 2 □ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie (Check only one) Certifying Phyafcfan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. PETER PUSHKAS, 11510 OLD GEORGETOWN ROAD, ROCKVILLE, MARYLAND 20852

State Registrar

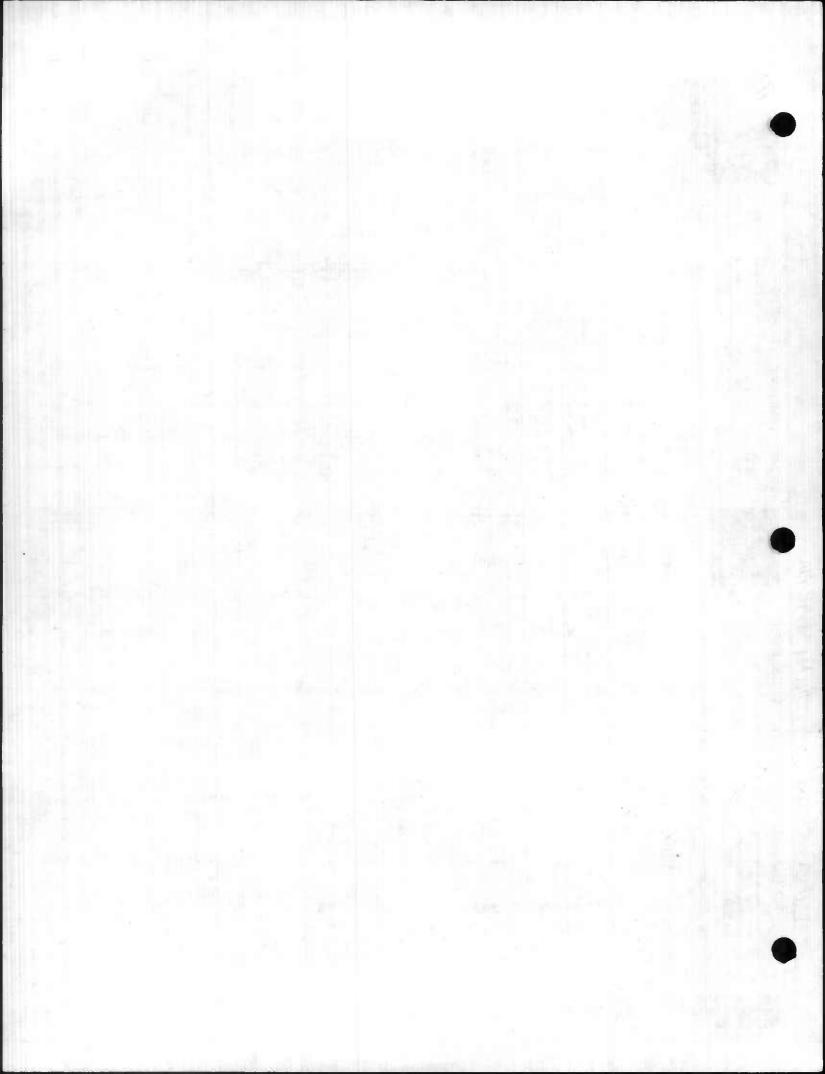
31. Date filed (Month, Dey, Year)

JUL 2 6 1999

32. Registrer's Signetura

To the Hospital e within 24 hours a To the Funeral D

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(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number O.C.M.E. July 22, 1999 s of person who complated causa of death (Itam 23a) (Type, Print) 30. Name and addre es

State Registrar 05

JUL 24 1999

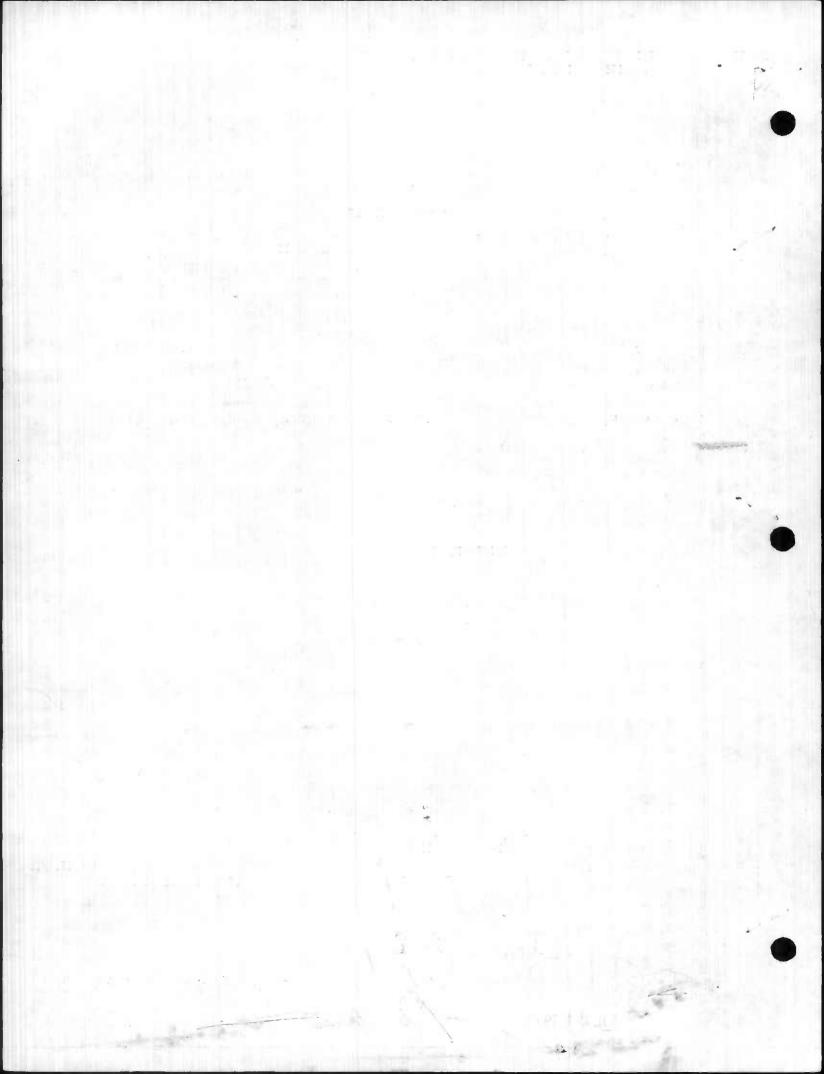
Day, Year

32. Registrar's Signature

anes

111 Penn Street, Baltimore, Maryland 21201

To the



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First Middle, Last) 2. Data of Death 3. Tima of Death Month July 26, 12:05 AM Helen Lillian 1999 Murphy 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, giva street and number) 4c. County of Death 1602 Cass Dr. Harford Bel Air If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 6. Sax Months Days 1 M 20 F Yrs. Mar. 5, 1916 83 Maryland 216-10-2902 Usual Rasidance of Decedant 10d. Insida City Limits 10a Stala 10b. County 10c. City, Town or Location 1 ☐ Yas 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? USA 1602 Cass Dr. 21015 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian. Black, Whita, atc. 1 ☐ Yas 2 XNo If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married 1 Yas 2 No Spacity: Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grade complated) Elemaniary/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home 18. Mothar's Nama (First, Middle, Meiden Sumema) 17. Father's Nama (First, Middla, Last) James Walter Mabel Elizabeth Anderson Paxton 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 302 Flintville Rd., Delta, PA 17314 Karen Laing/ Granddaughter 20b. Place of Disposition (Nema of cematary, cramatory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Hopewell Cemetery 7-29-99 Port Deposit, Maryland 22. Nama and Addrass of Facility
McComas Funeral Home, P.A. 21. Shapatum of Funaral Sarvice Licansa 1317 Cokesbury Road, Abingdon, Maryland 21009 lomas 23a. Part1. Entur the isaasa, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or hum dilure. List only one ceuse on each line. Intarval Batween Onsat and Daath Immediata Causa (Final disaese or condition rasulting in death) Carcinoma Lung Due to (or es e consequence of): Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of): Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of ceusa of death? 200 No 1 ☐ Yas 2 No 25. Wes case refarred to medicel examiner? 26. Placa of Death (Check only ona) Hospital: Other: 4 ☐ Nursing Homa 5 ₺ Rasidance 6 ☐ Other (Specify) 1X Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 1 X Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be detarmined 3 Suicida 28a. Placa of Injury - Al homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicide 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

that the death certificate be executed Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: **Physician**

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental thygiene. Important: If Item 27 ia marked other than "natural", or hema 23a or 28a-f ahow any injury or other traumatic event, it a Medical Experiment must be notified as

Physician

/Medical

Examiner

physician and s the burial-transit

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After this

death.

after death Director:

Examiner

Physician/Medicai

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Completed

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Certification: To

Medical

(Check only one)

29b. Signature and title of certifier

31. Deta filed (Month, Dey, Year)

Baltimore, Maryland 21215-0020

24 hours a To the Vithin 2

Registrar



30. Nama and addrass of person who completed cause of deeth (Itam 23a) (Type, Print) G. Prabhu, 218 Fulford Ave., Bel Air, MD

DMG

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29c. Licansa number

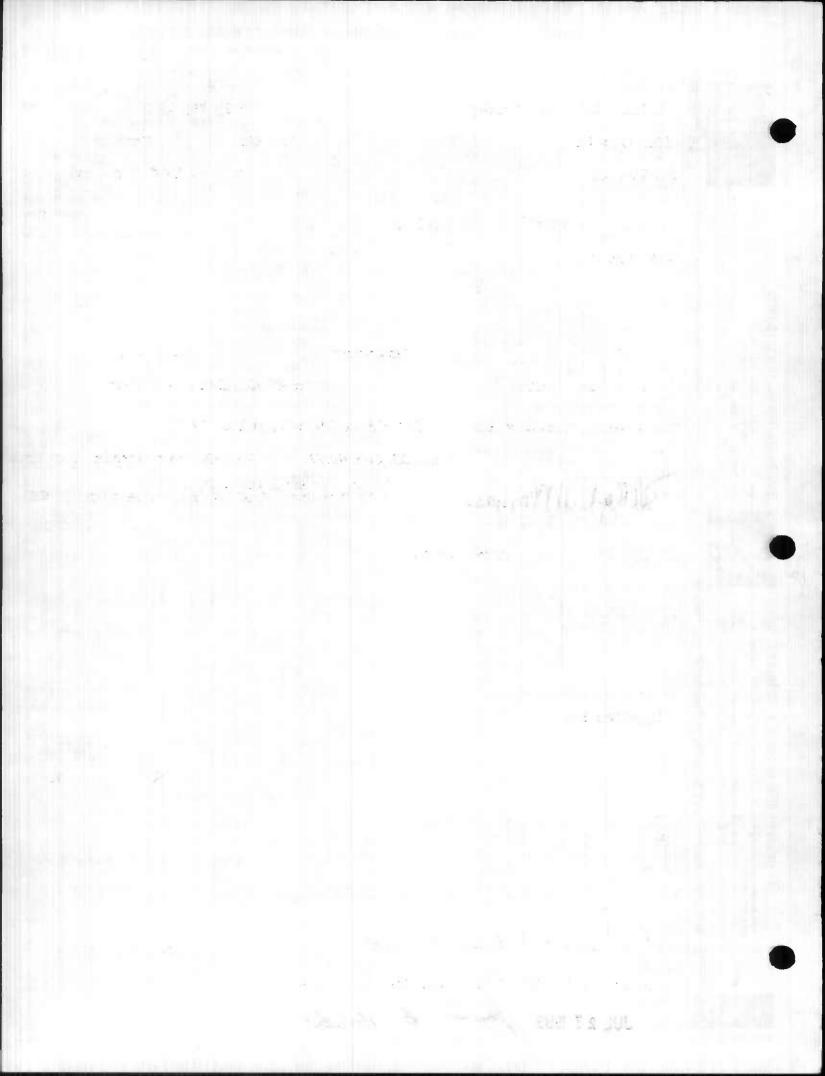
21014

OCME

29d. Data signed (Month, Day, Year)

July 26, 1999

DHMH 16 Rev 6/95



Piease Type or Print in Black Indelibie ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 9 25 1 4 5 Certificate of Death 2. Dete of Death 3. Time of Courth 1. Decedent's Name (First, Middle, Last) 619 Day 25 Month 19 m FRASER KILPATRICK MACAULAY 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Mariner Health of Bel Air Bel Air Harford If Undar 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthpiace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1√2 M 2□ F Yrs. 076-01-3907 85 July 11, 1914 Scotland Usual Rasidance of Dacedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 200No Maryland Harford Fallston 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2711 Harford Road 21047 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 20 Merried 1 Yes 21 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) Collage (1-4or 5+) Auto Mechanic Automobile Repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) u/k Kilpatrick James u/k Macaulay Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rural Route Number, City or Town, Stete, Zip Code) Helen F. Macaulay 2711 Harford Road, Fallston, Maryland 21047 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gardens7/29/99 Fallston, Maryland 21. Signatura of Funarel Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD Inter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. Do not enter heart failure. List only one cause en each line. Interval Between Onset and Death immediate Cause (Final diseasa or condition resulting in death) Audent 10 days Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaasa or injury that initiated events resulting in daath) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably A Unknown 24b. Were autopsy findings svaliable prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

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Completed

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filed within 72 hours after death v Hygiene. other than "naturel", or items 23

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Baltimore, Maryland 21215-0020

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29b. Signature and title of certifier

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> State Registrar

25. Was case referred to medical examiner? 1 Yes 2 No 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one)

29c. License number

1 Air

29d. Date signed (Month, Dey, Year)

30. Name and address of person who complated causa of death (Item 23a) (Type, Print) Scott

Haswin North Avenut 31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 9 9

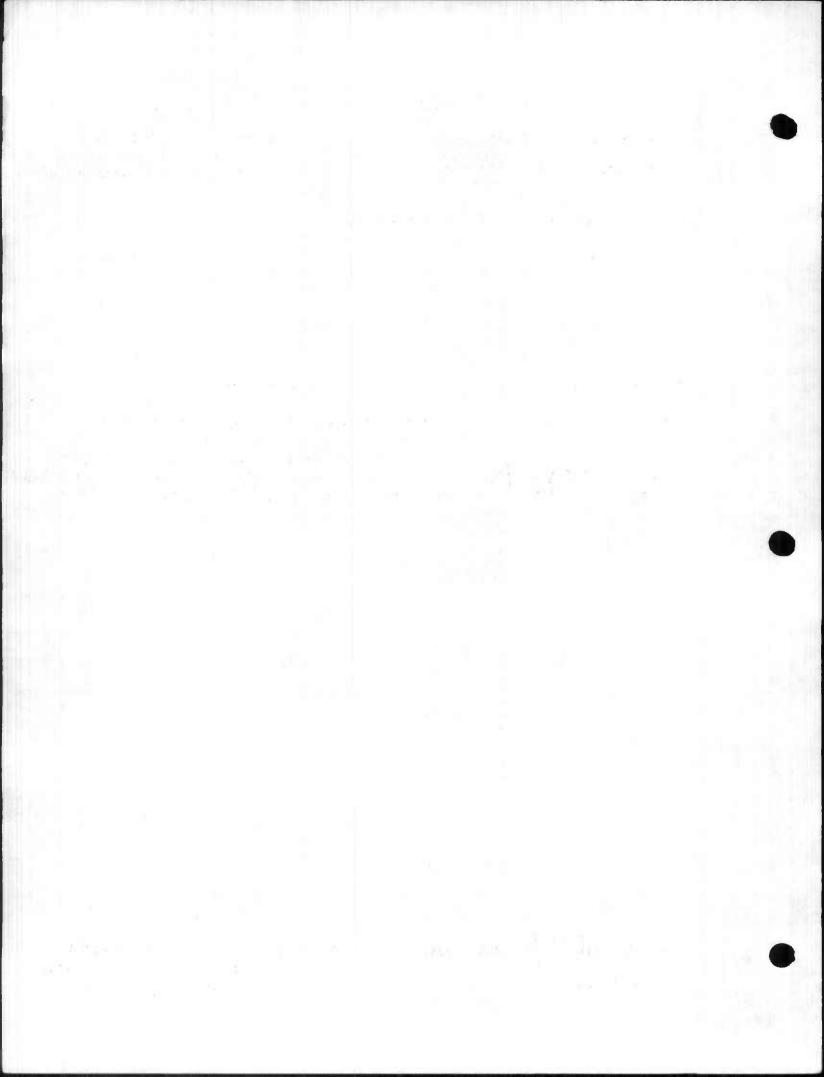
Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** 26, MacARTHUR NANCY H. JULY 7:15 PM 1999 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1509 STATESIDE DR. SILVER SPRING MONTGOMERY If Under 1 Yaar If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) **Funeral** Days Months Hours 1□M 2XF Yrs. 76 512-22-1281 Director MARCH 2, 192 KANSAS Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show ahow 1 X Yes 2 ☐ No Director MD. MONTGOMERY SILVER SPRING 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or filed within 72 hours efter death with STATESIDE DR. 1509 U.S.A. 20903 Funeral Herna 2 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No if Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merifel Status permit. Pages 1 and 2 should be filed within 72 hours effer d Department of Health and Menlet Hygiens. Important: If Itam 27 is marked other than "natural", or then eny injury or other traumatic event, the Medical Emarke Bleck, White, etc. 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced WHITE Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) MATHEMATICIAN JOHNS HOPKINS HOSP'T Baltimore, Maryland 17. Father's Neme (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) Be HOMER HENDERSON KATHLEEN O' CONNELL 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDGAR H. MacARTHUR/HUSBAND SAME AS TTEM 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) 7/28/99 CHAMBERS CREMATORY RIVERDALE. MD. 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility ranlesad MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between Onset and Deeth **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical 2 week brovascu Examiner Due to (or es e consequence ot) Examiner The law requires that the death certificate be executed physician end the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or injury that initieted eventa resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy tindings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medicel axaminar? Be 26. Place of Deeth (Check onlyone) 2 No Hospitel: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Medical Certification: To this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - Af home, ferm, street, fectory, office building, etc. (Specify) 2 4 I Homicide filled in To the Hospital 29e. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es atated. completely 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 2 JONES, JANET M. M.D. 11120 NEW HAMPSHIRE AVE. #305. SILVER SPRING, MD. 20904 Day. 32. Registrer's Signeture 31. Data filed (Month. State 1999 Registrar

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12+1 Daniel E Xum wo 16000 (MS) 7 27 197 30. Nama and addrass of person who completed causa of daeth (Itam 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENDAVID E. ALLEN, LT, MC, USNR BETHESDA MD 20389-5600	• Hospita 24 hours	letely fille		(Check only 2	Certifying Ph Medical Exar	niner: On tha ba	sis of exam	knowledga, daath nination and/or inv	occurred at the ti astigation, in my	ma, data and place, opinion, daath occurr	and dua to the red at tha tima	a causa(s) and ma , data and place,	annar as stand dua to	ated. tha causa(s)
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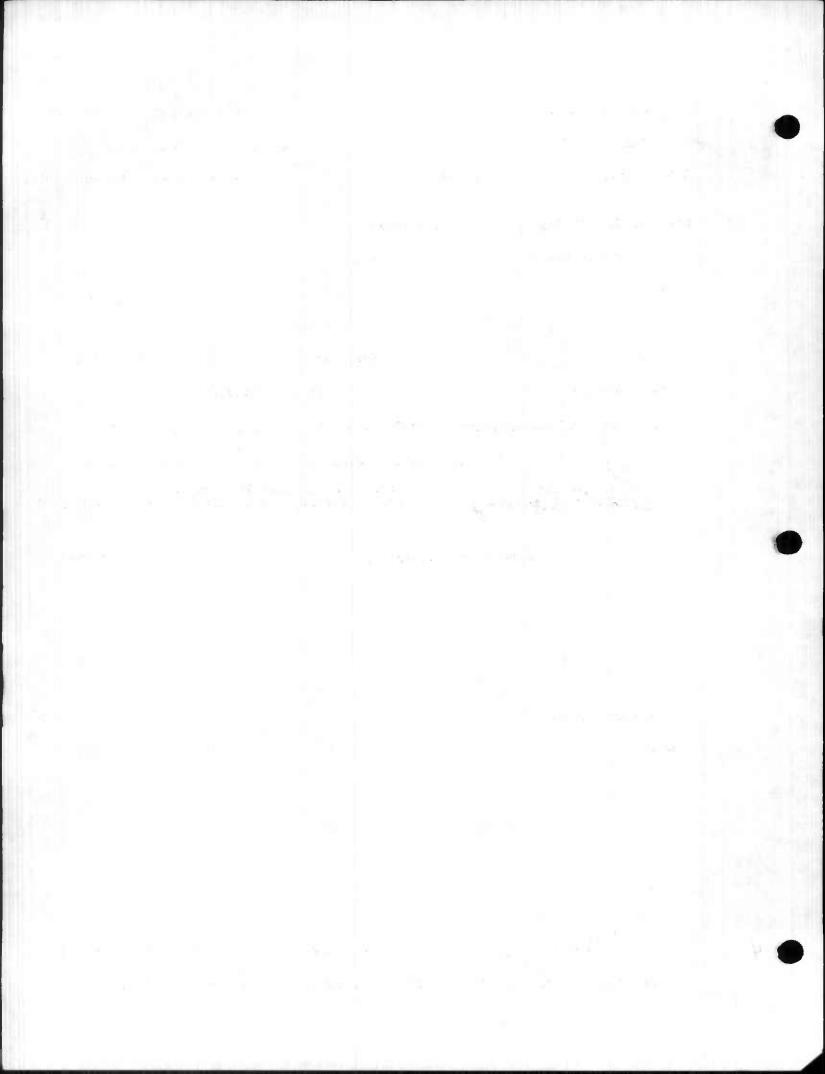
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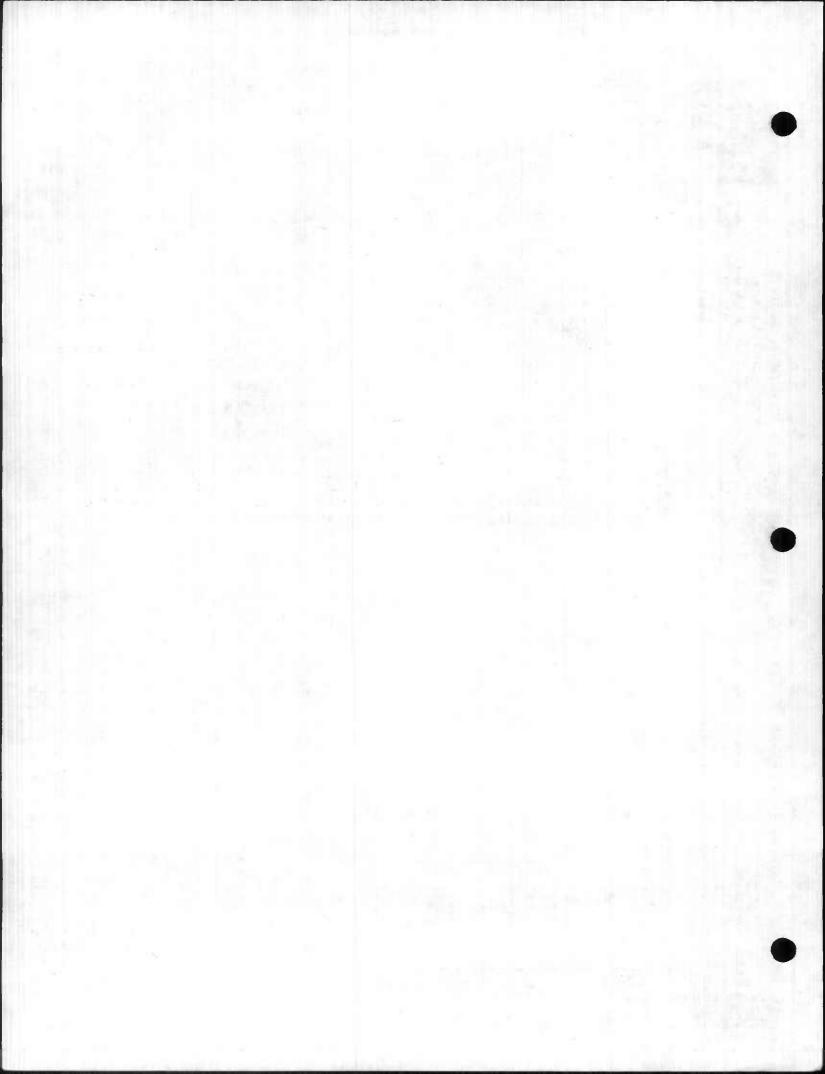
Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** July 25,1999 Margaret A. McDonald /Medical 7:00pm 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Mon r If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Montgomery
9. Birthplace (State or Foreign Country) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** 1 □ M 2√2 F Months Deys Yrs. 579-28-4547 Director 88 May 19, 1911 Washington, DC Usual Residence of Deceden the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street end Number 10g. Citizen of Whet Country? 9 10311 Gilmoure Drive or items 23a 20901 death USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20XNo If Yes, Give 11. Meritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Biack, White, etc. hours aftar 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates than "natural", ted 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Complet Elementery/Secondary (0-12) College (1-4or 5+) 12 Review Specialist Federal Government markad other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd 2 should be fi lith and Mental F 27 Is marked off r traumetic aver Martin McDonald 70 Sarah Gallagher 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum Kevin Joseph McDonald/Nephew 12037 Crimson Lane, Silver Spring, MD 20904 lece of Disposition (Name of 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition July 29 1 ₺ Buriel 2 □ Cremetion 3 □ Removel from State Mount Olivet Cemetery 5 Other (Specify) 4 Donelion 1999 Washington, DC 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, MD 20901 the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, Enter the disease, or complications that cause, or heart failure. List only one cause on easy ii. Approximete Intervei Between Onset and Deeth Physician /Medical Immediate Ceuse (Finei disease or condition resulting in deeth) e. Myocardial Infarction Sudden Examiner Due to (or es e consequence of) Examiner be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest bunal-tran and Due to (or es e consequence of): Box 68760, physician Physician/Medicai Due to (or es e consequence of) 88 attending for use as P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Alzehimers Disease Records, ρ 24b. Were autopsy findings aveileble prior to Be Compieted 24e. Wes en eutopsy peen Dementia completion of cause of deeth? page 2 this certificate 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, i 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1X Yes 2 No 1 Inpatient 2 XER/Outpetient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Naturai 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filted in edicai 29e. Certifier 1 Kcertifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 Medical Exeminer: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signatule end tie of certifier 29c. License number 29d. Date signed (Month, Dey, Year) mpa D-32332 July 26, 1999 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Suresh Kumar Gupta, MD 9801 Georgia Ave., #220, Silver Spring, MD 20902 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Deneva 1999 Registrar JUL 27

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State of Maryland / Department of Health and Mental Hygiene 9 25 | 4 9

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0020 ours after death ref., or items 23 Examiner mus	by Funeral	11. Marital Status 1 □ Nevar Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent If Armed Forces? 1 X Yes 2 N If Yes, Giva Year or Dates:1	ło	If Yes,	Decedent of I specify Cub as 2 X No	lispanic Ori an, Mexican Specify:	gin? (Spec I, Puarto R	ify Yes or No- ican, atc.)		ce - Amarica ck, White, a v: Whi	atc.	
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and be	o Be	Wilmer					hor						
Maryland 21215-0020 62 should be filed within 72 hours at th and Merical Hygiene. 7 is merked other then "natural", or precimatic event, the Medical Exam	To	19a. Informant's Name/Relationsh Susann Davis Mat			Mauck Elizabeth Kirkwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code, same as #10								
C - 50 M - 1		20a. Mathod of Disposition	tor (dadgiro	20b. Place of		- 11			Defa	20c. Location -	City or To	wn. Stete	_
Baltimore, semil, Pages 1 a Department of Hea mportant: if Item;		Warial 2 □ Cremetion 4 □ Donation 5 □ Other (Sp.	Mount	y, crematory	y or other pla		7/28/				Maryland		
Ball Depart		21. Signature of Funeral Service L	Bouns	H	Dona.		Borgw	ardt		1 Home,		Land 2070	15
		23a. Part1. Enter the disease, or constant. List of the shock, or heart failura. List of	omplication that caused	the death. Do n	not entar the	mode of dyir	ng, such es	cardiac or	respiretory err	est,	Marai	Approximate Interval Between	5_
Physician		orion, or nour rollars. Elect									1	Onset and Death	
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ned ned	Examiner	e i e i e	b								- 1		
. Box 68760, death certificate be executed e attending physician and of for use as the burial-transit	edicai Exa	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events	C	CDue to (or as a consequence of): Due to (or as a consequence of):									
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	tlon: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigs	28a. Data of Injur (Month, Day	y 28b. T	ima of njury M	28c. Inju		28		ow injury occur			
Division or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could no detarmin	ury - At homa, fac c. (Specify)	rm, street, fa	actory, office		28	8f. Location (S City or Tow		per or Rura	l Routa Number,		
Hospita 4 hours Funeral tely fille	edicai C	29a. Certifiar (Check only one) Certifying			ause(s) and ma late and place,								
within 2 To the comple	Me	29b. Signature and title of cortiller	and manner sta			29c. Licens	e number		29d. Data signed (Month, Day, Year)				
F 3 F 8	30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) RAYMAND BASS 3941 FERRARA WHIFATON MD 2093								JULY				
. (30. Name and address of person w		eath (Item 23a) (Type, Print)	1	1/HEA	TOAL	MO	7042	,	. , ,	
S	RAYMAND BASS 3941 FERRARD WHISTON MD 20906 tate 31. Data filed (Month, Day, Year) 32 Register's Signature							117.0					
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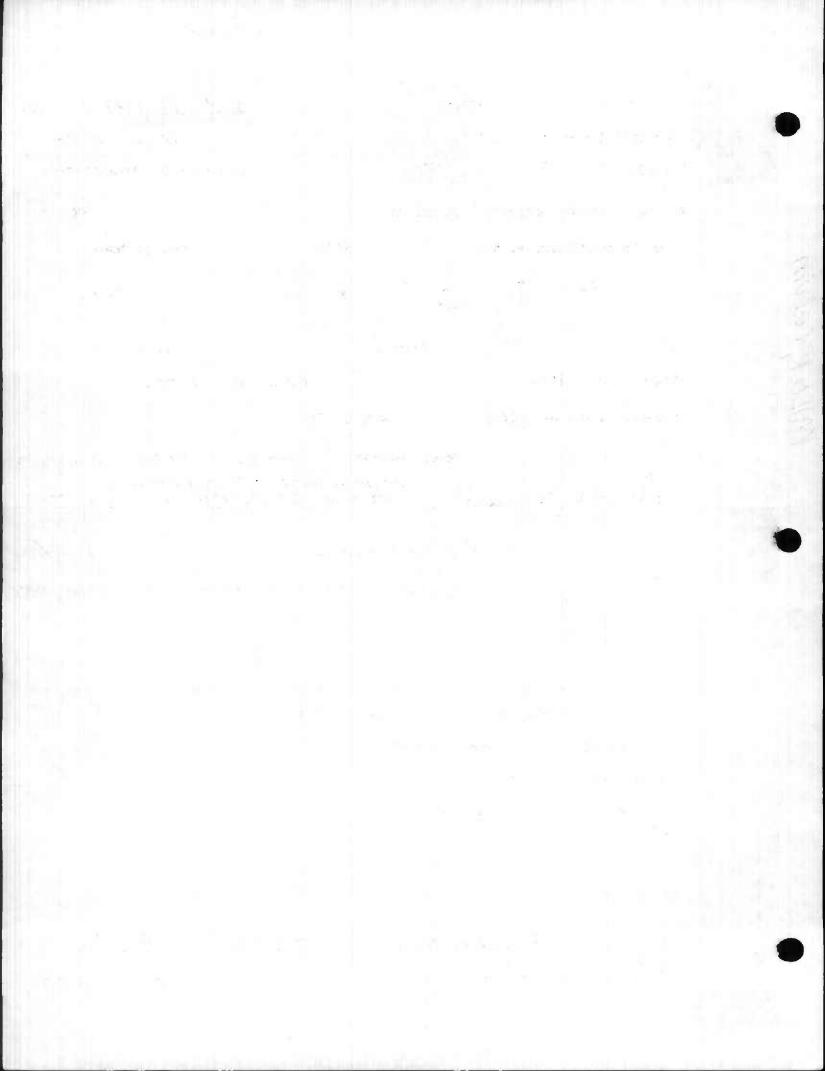


State of Maryland / Department of Health and Mental Hygiene 9 9 25 | 50

						Cer	tificate of	Death		Reg. No.	Goods	0 1 0 0			
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	Physici /Medic		Calvin	A.L. Mi	ller				Month	Day 27	gaga .	2:22 PM			
	Examir		4a. Facility Nama (If not institution, g	riva street and number,)			4b. City, Town, or I	Location of Deat	4c. County	of Death				
			Doctor's Commun	ity Hospit	al			Lanham		Princ	ce Ge	orge's			
	Funeral Director		176-16-1283	Sex 7. A	ge (In yrs.	79 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da Apr. 10	1920	9. Birthp Court Penn:	place (Stata or Foraign htty) sylvania			
	h the Maryland r 28a-f show	2	Usual Residence of Decedent 10a. Stata 10b. County Maryland Prince	George's		, Town or Loc					1	10d. Inside City Limits			
	Sa or 28a-f	Funeral Director	10e. Street and Number 6996 Hanover Pa	rkway, #20	1		10f. Zip Code 2077	70		10g. Citizen of V		ntry?			
Calvin	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinal must be notified at	þ	11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorcad	12. Wes Decedent Armed Forces' 1 X Yes 2 If Yes, Give Yaar or Dates:	No No	1	Vas Decedent of I Yes, specify Cub	Hispenic Origin? (Spean, Mexican, Puerti Specify:	pecify Yes or No o Ricen, etc.)		e - Amarlo ck, White, v: Wh:	etc.			
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MILLER re, Maryland 21:	nd 2 should alth end Men 27 is marke r traumatic						g Address (Stree	t and Number or Ru ‡10	rel Route Numb	er, City or Town,	Stata, Zip	Coda)			
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Baltimor	Page ment ant: If ury or		MBurial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec			ps Cem	etery	July	31, 199	9 Hyndma	n, Pe	ennsylvania			
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	Examiner		isease or condition a. Due to (or as e consequenca of):												
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	To the To the	X	29b. Signature and title of certifier	.0 01		*		se number	20	29d. Date signe	d (Month,	Day, Year)			
	6			d sel				1757	2	/2	28/	49			
	,		30. Name and address of person who	completed cause of c	Death (Item	23a) (Type, F	enteru	1 cy 9	reen	helt	MP	20770			

G. Sparks

State Registrar



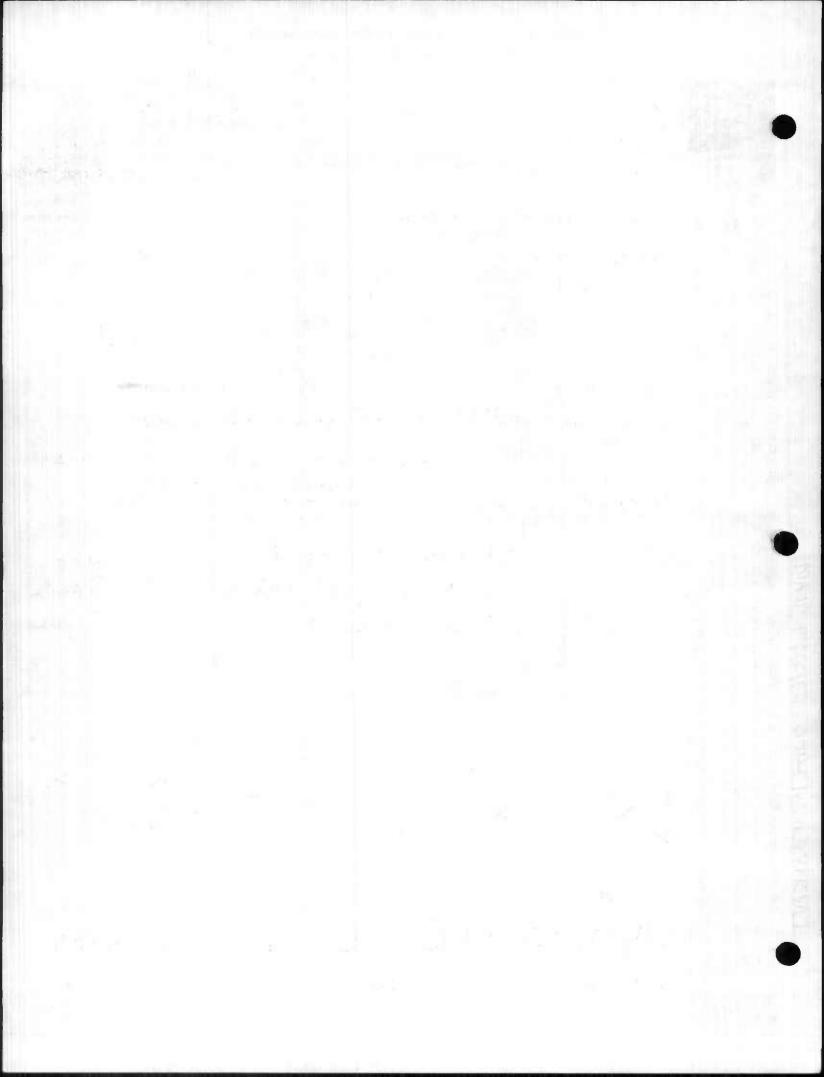
State of Maryland / Department of Health and Mental Hygiene Q

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s 1 and f Heelth fem 27 other tr		20a. Mathod of Disposition		20b.		Disposition (No., crematory or				Data	20c. Location		own, Stata	
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permit. Pages 1 and 2 should be filed within 72 hours Department of Heelith and Mental Hygiene Important: if Item 27 ie marked other than "natural", any injury or other traumatic event, tra Medical Exa once.		21. Signature of Funarai Sarvice License	a							es, P.A			,	
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15		► Make MON) W	0		0 2	1125	5		MINT	23	1777	
17		30. Nama and addrass of person who cor)			
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Laverty, Cheryl Lane 07/22/99 10AM

Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Catherine Gainey Orvis July 7:55 A.M. 27, 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 27, 1918 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 ☐ M 2 🕱 F Michigan Yrs 369-18-4487 80 Director Usual Residence of Decedent the Manyland 10a Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow result be notified at MD Montgomery Bethesda 1X Yes 2 No Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 6 Herns 23s 5304 Camberley Avenue 20814 Funeral U. S. A. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Bleck, White, etc. filed within 72 hours after Hygiena. Ther than "natural", or ite 1 Yes 2 No if Yes, Give Yeer or Detes: 1 Never Married 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient important: if fem 27 is marked other that any injury or other traumatic access. Homemaker Own Home 5 + 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be George Gainey Fidelia Finlan 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Byron L. Orvis - Husband 5304 Camberley Avenue Bethesda, MD 20814 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 7/30/99 Silver Spring, Gate of Heaven Cemetery 4 ☐ Donalion 5 ☐ Other (Specify) 22. Name and Address of Fecility Joseph Gawler's Sons 21 Signature of Funeral Service Licenses E. Jambaker 5130 WI Ave. N.W. Washington, D. C. 20016 B 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Cerebrovascular Accident diseese or condition resulting in deeth) 6 Days Examine Due to (or as a consequence of): Examiner Cerebal Atherosclerosis certificate be executed physician and s the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Last Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of): 980 Part II. Other algnfficant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by 1宮Yaa 2□No 3□Probably 4□Unknown Carcinoma of the Lung by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Chronic Obstructive Lung Disease page 2 certificata has 1 TYes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 TYes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, lerm, street, lactory, office building, etc. (Specify) 4 Homicide edical 29e. Certifier i Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis and examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Fernwood Road -Bethesda, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Levin, mi 13412124 10 31. Dete liled (Month, Dey, Year) 32. Røgistrar's Signature State JUL 29 1999 Dener

Registrar

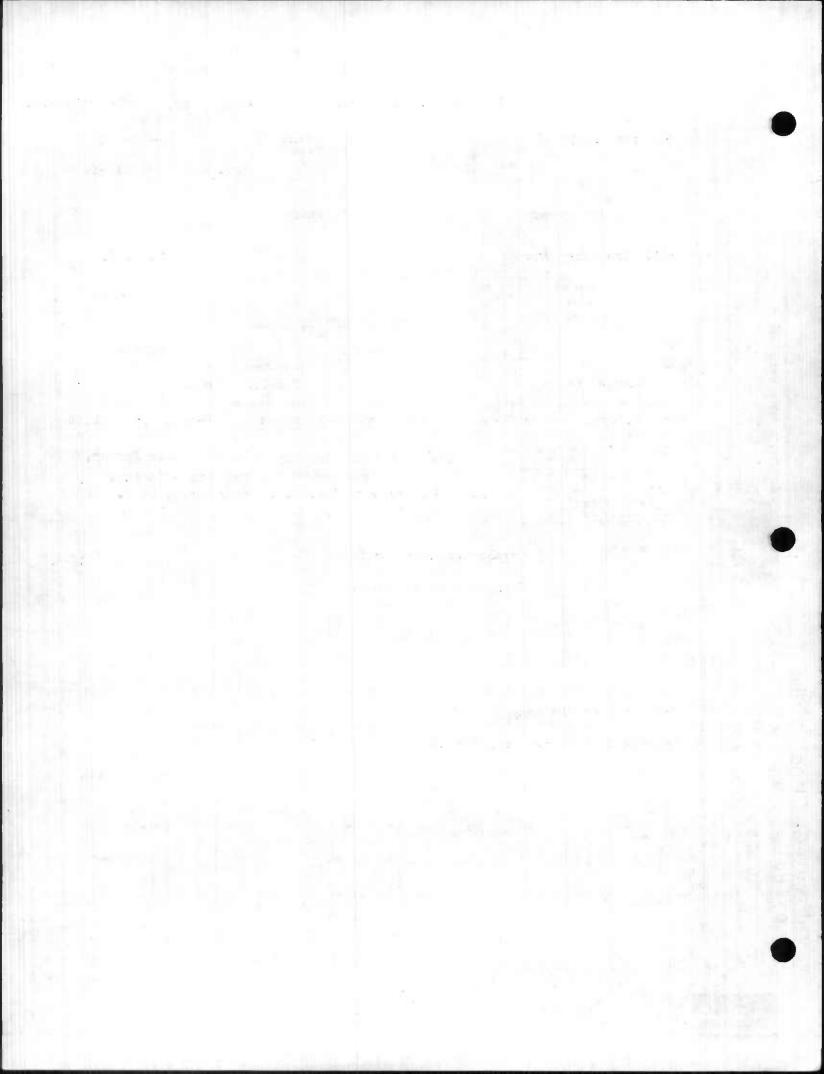
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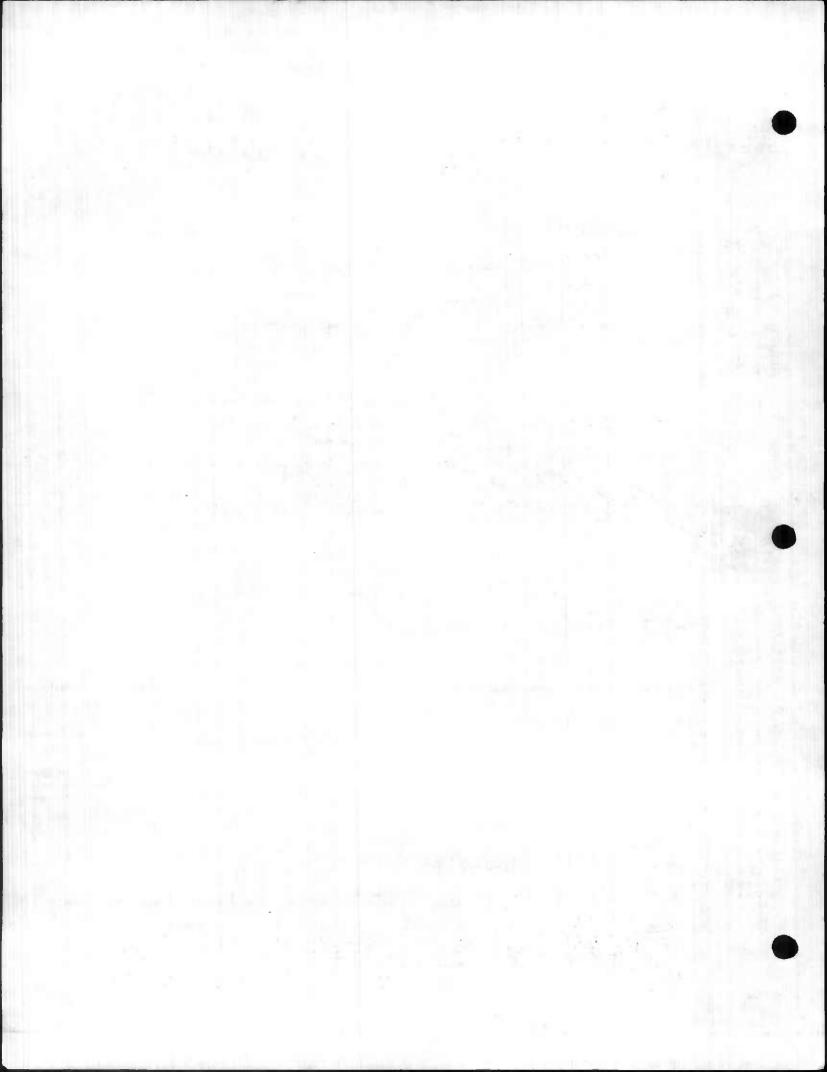
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State of Maryland / Department of Health and Mental Hygiene 99 25 153

			C	Certificate of	f Death	R	ng. No.	40	133						
		Decedent's Name (First, Middle, Last)				2. Date of Deat	h	Year 3. T	ime of Death						
	Physician /Medical	John A. Pauritsch				July	23, 1	999	10:31 AM						
	Examiner	4a Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Death	4c. County	of Death							
19		Montgomery General Hospital			Olney		Montg	omery							
	uneral Director	5. Social Security Number 6. Sex 1 7. Age (In yr 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Months Day		8. Date of Birth (Month, Day, May 3		9. Birthplace (S Country) Illinoi	State or Foreign						
P		Usual Residence of Decedent	0. 7												
Maryla	and show	Maryland Montgomery	City, Town o	Iney					Yes 2 No						
with the	Sa or 28a-f a at be notified al Director	10e. Street and Number 4352 Morningwood Drive		10f. Zip Code	20832	10	Og. Citizen of W	hat Country?							
5-0020 72 hours after death with the Maryland	raf, or tems 23s or 28s-f show Eseminar must be notified at by Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 □ Never Merried 2 ☑ Married 1 ☑ Yes 2 □ No	U,S.		f Hispanic Origin? (S uban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race Black	- American Ind k, White, etc.	ian,						
005 ours	by F	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 €	976	1□Yes 2頃N	lo Specify:		Specify:	White	2						
5-0 72 h	"natural",	15. Decedent's Education (Specify only highest grade completed)	rkina	16b. Kind of Bu	siness/Industry										
d 21215-0020	E	Elementary/Secondary (0-12) College (1-4or 5+)			ne during most of wo ired)										
D P	S S	17. Father's Neme (First, Middle, Last)	Pro	ject Manag		ne (First, Middle, A	IBM	n)							
	marked other umatic avent, in To Be Co														
larylan	7 le marke traumado		10h A	Anilina Address (Str											
	2.5														
Te, M	Item 2 other		. Place of D	isposition (Name of											
Baitimore,	Important: If he any injury or of ance	1 ဩ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lightness		aryland											
m 88	FER	Commercial Commercia													
Phy	sician C	Part I. Enter the absence of complications that Caused the de shock, or heart failure. Let only one cause on each line.						Appro							
/M	ledical aminer	Immediate Cause (Final disease or condition resulting in death) a. Hypoxemic R		The state of the s	lure			3 D	ays						
	5	Due to		. / D											
5	ng physician and set the buriel-transit Medical Examiner	Sequentially list conditions.			4 D	ays									
o,	dal-tr	if any, leading to immediate		1554861105 617.				14 D	2770						
68760,	se the bur	that infleted events		sequence of):				14 0	ays						
X	nding ph use as th n/Med	resulting in death) Last	24 M	onths											
BC BC	d for use	Part II. Other significant conditions contributing to death but not re	manufation in th	a undarkina sausa	sinos in Rad I	22h Did to	hacco usa con	tribute to the c	ausa of death?						
P. P.	igned by the attendit be detached for use by Physician/I	Cartin. Outed significant conditions contributing to death but not h	esulang in tr	te uncertying cause	gwen in rait i.				4 Unknown						
Records,	2 should					24a. Wes a perform		24b. Were aut available completic of death?	prior to on of cause						
	page page					1□ Ye	s 2 No	1 ☐ Yes	2⊠ No						
Vital	certificate frector, pag	25. Wes case referred to medical examiner?			26. Place of De	ath (Check only on	e)								
of Vita Physicien:		Hospital:	☐ ER/Outpa	atient 3 DOA	Other: 4 Nursing I	forme 5 Reside	nce 6 Othe	or (Specify)							
Vision of Attending Physic death.		27. Manner of Death 1 ⊠Netural 5 □ Pending 2 □ Accident investigation 28a. Dete of Injury (Month, Day Year)	28b. Tim Inju	iry V	ijury et Vork? □ Yes 2 🖾 No	28d. Describe ho	w injury occurr	ed							
Division to Attending a after death.	el Director: After i led in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, ferm cify)	, street, fectory, offic	ж	28f. Location (St. City or Town		er or Rural Rout	e Number,						
Hospital 24 hours	To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one) 2 Medical Examiner on the best of my key one) 4 Medical Examiner on the best of my key one)							ause(s)						
thin	Me Me	29b. Signeture and title of certifler		29c. Lice	ense number	2	9d. Date/signed	Month, Day, Y	'ear)						
P P	n 47	V) (Jahr / Lan ms	ь		1908		7/23	199							
V		30. Name and audiress of person who completed cause of death (It	em 23a) (Ty		Olup.	m.0	208	22							
	State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature	1	- inity										

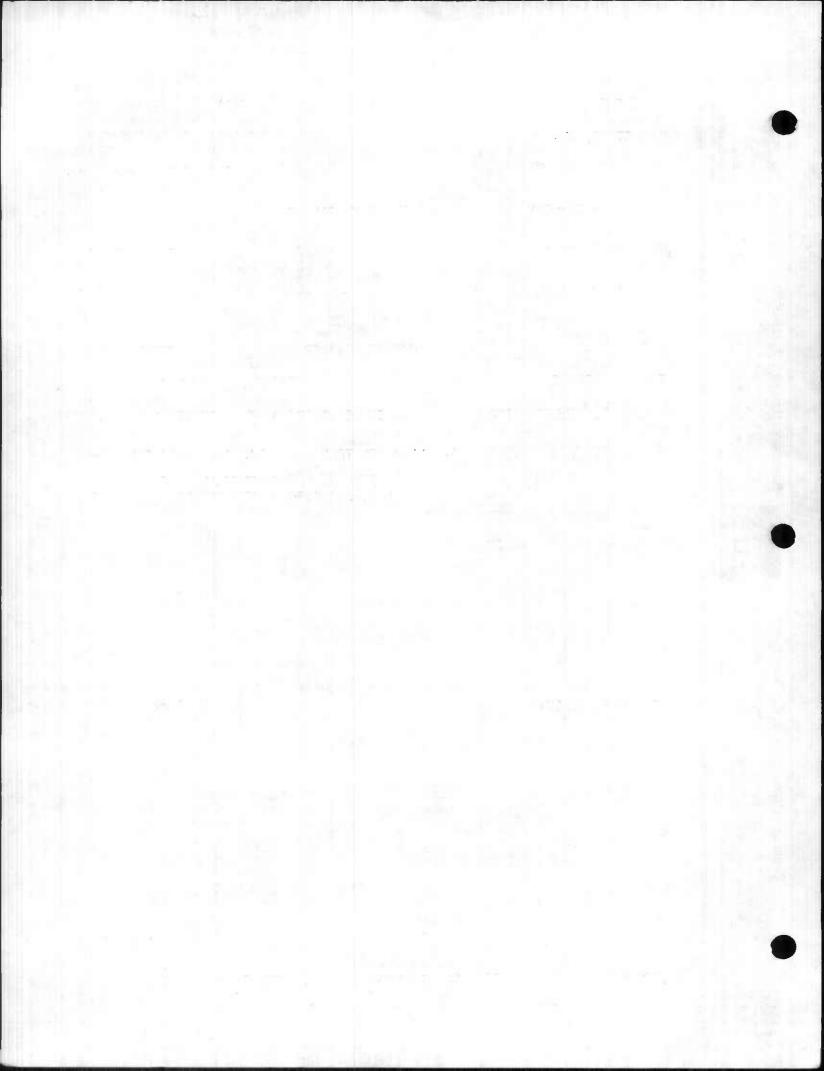
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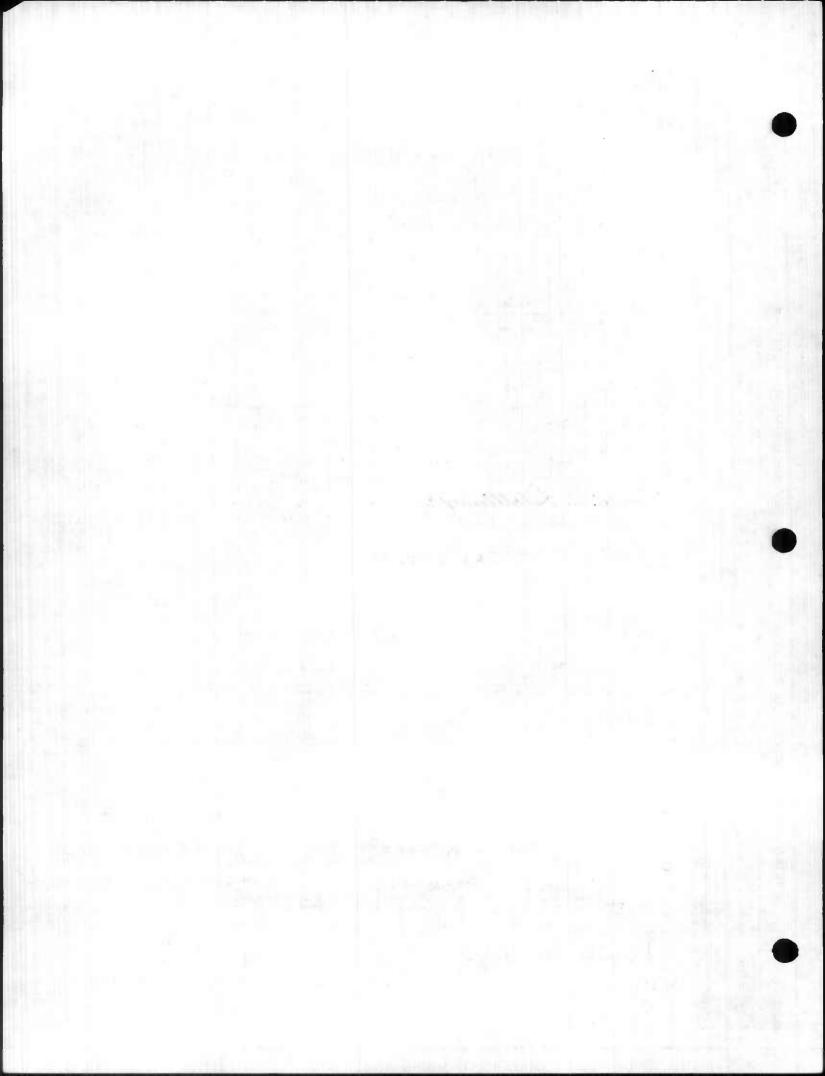
			Cen	rificate of	Death	×	Reg. No.	20104	
Physician	1. Decedent's Nama (First, Middla, La	ist)				2. Data of De Month		3. Time of Death	
/Medical	WILFRED	0	F	ELLET			1, 1999	8:40 PM	
Examiner	4a Facility Nama (If not institution, given 20402 STUDIO PLA				4b. City, Town, or L MONTGOMER				
·		Sex 7. Aga (In yrs. li	ast birthday)	If Undar 1 Yaar	If Under 24 Hrs.	8. Date of Bir		OMERY Birtholace (State or Foreign	
Funeral Director		1 2 4M 2□F 89	Yrs.	Months Days	Hours Min.	MAY 12		P. Birthplace (Stata or Foreign Country) New Jersey	
e Marylan le-Febow filled.at	MD. 10b. County MONTGOM		MONTGO	ation DMERY VI	LLAGE			10d. fnside City Limits 1 ☐ Yes 2 📆 No	
th with the Maryla 23e or 21e-f sho ust be notified at rail Director	10e. Street and Number 20402 STUDIO PLA	CE		10f. Zip Code	0886		10g. Citizen of Wh UNITED S		
21215-0020 d within 72 hours after death v plens r then *netural*, or items 23s the Medical Examiner must	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evar in U, Armed Forcas? 1 □ Yas 2 No If Yas, Giva Yaar or Detas:		as Decedent of I Yas, specify Cub	Hispanic Origin? (Sp an, Maxican, Puarto Specify:	ecify Yas or No Rican, atc.)	14. Race - Black, Specify:	American Indian, Whita, atc. WHITE	
od within 72 ho spiere. we then 'neturion's the Medical is	15. Decedant's E (Specify only highest gr	ducetion ada completed)	(Giva k	nt's Usual Occu ind of work dona	during most of work	ing	ness/Industry		
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	17. Fathar's Name (First, Middla, Last	-	CKEL	IT MANA		a (First, Middle	RETAIL Maiden Sumama)		
yland whental h whental h arked off arke ever	OTTO DELLET		IRENE		ERONEAU				
Aar 2 sh 2 sh 1 s m	19a. Informant's Name/Ralationship (PAULINE T. PELL	Type, Print) ET, WIFE			and Number or Rui	al Routa Numb			
Baltimore, North Pages 1 and Journal of Health Pages 1 and Department of Health International Intern	20a. Mathod of Disposition 1 Rurial 2 Cramation 3 L 4 Donation 5 Other (Speci	Removal from State	20402 STUDIO PLACE, MONTGOMERY VILLAGE, MD.: Ob. Placa of Disposition (Nama of cematery, cramatory or other place) PARKLAWN CEMETERY 7/24/99 ROCKVILLE, MI						
altin mit. Pa partmen cortant: rinjury	21. Signetura of Funeral Sarvice Lice				BARBER			L, NO.	
m Falls	> muriel	1. Barker	/ P	ORIEL H	5038, LA	TONERAL	HOME	20882	
THE REAL PROPERTY.	23a. Part1. Entar tha disaasa, or com shock, or haart failure. List only	plications that caused the death						Approximata Interval Between	
Physician								Onset and Death	
/ /Medical Examiner	tmmediata Causa (Final disaasa or condition resulting in deeth)	LUNG CANCE	: R					WEEKS	
	resulting in deedily	Due to (or	es a consequ	ance of):					
executed in and instransit		b						1	
8760, sate be executed shysician and the buriel-transit dical Examir	Sequentially list conditions, if any, leading to immadiata cause. Entar Undartying Cause (Disaase or Injury	Dua to (or	as a consequ	ence or):					
68760, ficate be an physician is the burie	Cause (Disaase or Injury that initiated evants rasulting in death) Last	c Dua to (or	as a consequ	ance of):					
mg phang phang by Med	rasulting in death) Last								
Box eath cert attendin Ifor use		d	<u> </u>						
P.O. BOX at the death ce the death ce stached for use Physician/	Part II. Other aignificant conditions of	contributing to death but not rasu	ven in Part I.	23b. Did	tobacco use contr	ibute to the cause of death?			
P.O. that the de detached detached	DIABETES MELLI	TUS				10	Yee 2KNo 3	Probably 4 Unknown	
Cords, requires speed should be						24a. Was	an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?	
The law ate has b page 2 s						10	Yes 25 No	1 Yas 2 No	
Vital I	25. Was case refarred to medicat				26. Place of Deal			10 100 2010	
of Vital Physician: This certifical ral director, p.: To Be C.	axaminar?	Hospital: 1 Inpatient 2 E	ER/Outpatient	3 DOA Ot	her: 4 Nursing Ho	. /	dence 8 Othar	(Specify)	
SION O tending Ph leath. for: Atter th the funeral	27. Mannar of Death 1. Natural 5 □ Panding	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju	ry et	28d. Describe	how injury occurred	1	
Attending or death. Sctor: Attention by the fune	2 Accidant investigatio	n		M 10	Yas 2□No				
DIVISION C bal or Attending P is after death. al Director: Attert led in by the funera Certification:	3 Sulcida 6 Could not be datarmined			et, factory, office		28f. Location (City or To	Street and Number wn, Stata)	or Rural Route Number,	
oltal oltal or sal Dilled i	00-0-4				SUIP. SEE A 10				
Ne Hospi n 24 hou Ne Funer pletely fil		ysiclan: To the best of my know niner: On the basis of examinati and manner stated.							
Division To the Hospital or Attending B within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer Medical Certification:	29b. Signatura and titla of certifiar	wine inwining statou.		29c. Licen	se number		29d. Data signed ((Month, Day, Year)	
20	1 ATO	Verma M	2)	DI	5046		JULY 22	2, 1999	
20	30. Nama and addrass of parson who DR.STEPHEN J. NEW	completed cause of death (Item		rint)		E MD			
State	31. Deta filed (Month, Day, Year)	32. Registrar's Signet				L, MU.	20002		
Registrar		999 Beneva	B.	Space	K				



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Porter		Cer	tificate of	Death		leg. No.							
					Month			3. Time of Death					
				4h City Town or	_			10:57 AM					
5. Social Security Number 6. St 213-42-5249	ex 7. Age (In y	rs. last birthday) 56 Yrs.	If Under 1 Year Months Days		(Month, Da)	Year)		e (Stete or Foreign					
10a. State 10b. County	10c.	City, Town or Lo	cation				10d.	Inside City Limits					
MARYLAND MONTGON	IERY	РОТОМАС						1 Yes 2 No					
10e. Street and Number			10f. Zip Code			log. Citizen of V	Vhat Country?	?					
		ua I.a.											
11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever if Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Yeer or Detes:				to Rican, etc.)		k, White, etc.						
(Specify only highest gra-	de completed)	(Give i	kind of work done	during most of wo	rking	16b. Kind of Bu	usiness/Indust	try					
12	College (1-4or 5+)	INT	ERIOR DE	SIGNER		DECOR	ATING						
17. Fether's Name (First, Middle, Last)							(6)						
				CIRCLE-									
1 ⊠ Burial 2 □ Cremetion 3 □	Removel from Stete	cemetery, crematory or other place)											
DN 110	A												
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	o (or as a conseq	uence of):										
that initiated events resulting in death) Last	Due to	o (or as a consequ	uence of):				1						
Part II. Other significant conditions co	ntributing to death but not	resulting in the un	derlying cause gi	ven in Part I.	23b. Did t	obacco usa col	ntributs to the	e cause of death?					
					101	'es 2 10	3 Probab	ly 4 Unknown					
				Lin	24a. Was a	an autopsy med?	availat	autopsy findings ble prior to letion of cause th?					
					181	es 2 No	18/1	es 2□ No					
25. Was case referred to medical				26. Place of De	eth (Check only o	ne)							
Yes 2□ No	Hospitel: 1 ☐ Inpatient 2	ER/Outpation	3LI DOX	4 LI Nursing I									
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4 Homicide determined					City or Tow	n, Stete)		lu					
(Check only , 2 Medical Exam	relcian: To the best of my liner: On the besis of exam	cnowledge, death	occurred at the ti		e, and due to the	ause(s) and ma	nner es state	d.					
ane)	and manner stated.												
Sold title of Cartillary	00 18 00		29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year) July 28, 1999										
Mugne Vo	worde		30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)										
30. Name and address of person who of MARA WITH A	ompleted cause of death (I			eet, Bal	timore, N	Maryland	1 21201						
	PAMELA MASON 4a. Facility Name (If not Institution, gives 11400 Cedar Ridges) 5. Social Security Number 6. St. 213-42-5249 Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGON 10e. Street and Number 11400 CEDAR RIDG. 11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest graves because Institute of	11400 Cedar Ridge Drive 11400 Cedar Ridge Drive 11400 Cedar Ridge Drive 5. Social Security Number 213-42-5249 1	PAMELA MASON PORTER 4a Facility Name (if not institution, give street and number) 11400 Cedar Ridge Drive 5. Social Security Number 213-42-5249 Susual Residence of Decedent 10a. State 10b. County MARYLAND 10c. CEDAR RIDGE DRIVE 11. Maritel Stetus 11. Maritel Stetus 12. Was Decedent Ever in U.S. 11. Was rite of the County 11. Was rite of the County 11. Was rite of the County 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 16. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 17. Father's Name (First, Middle, Lest) 12. LESTER MASON 19a. Informant's Name/Relationship (Type, Print) 19DHN DAVID FOUNDAS (SON) 188901 20b. Method of Disposition 15 Burial 2 Cremetion 3 Removel from Stete 4 Denetion 5 Other (Specify) 21. Signature of Funeral Service Licensee 123a. Part I. Enter the disease, or complications that caused in Journal County that initiated events resulting in death) 19a. Informant's Name/Relationship (Type, Print) 21. Signature of Funeral Service Licensee 22. Sequentially list conditions, any leading to immediate cause. Enter Underlying 2ause (Disease or Condition 25. Sequentially list conditions. 25. Sequentially list conditions. 26. Enter Underlying 27. Manner of Death 1 Neutral 1 Due to (or as a consequence of Death 1 Neutral 2 Conditions the cause of Injury (Month, Day Year) Due to (or as a consequence of Death 1 Neutral 2 Conditions the county of the Desis of examination and/or investigation and on the determined of Conditions o	PAMELA MASON PORTER 4a. Facility Name (if not histitution, give street and number) 11400 Cedar Ridge Drive 5. Social Security Number 213-42-5249 10a. State 10b. County MARYLAND MONTGOMERY 10c. City, Town or Location MARYLAND MONTGOMERY 10c. City, Town or Location MARYLAND MONTGOMERY 10c. City, Town or Location MARYLAND MONTGOMERY 10d. City, Town or Location MARYLAND MONTGOMERY 10d. City, Town or Location 10d. City, Town or Location MARYLAND MONTGOMERY 11. Maritel Stetus 11. Maritel Stetus 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Decedent's Education 15. Decedent's Education 16a. 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Social Security Namiber 123-42-5249 10M 22F 7. Age (in yrs. last birthday) 10 Fort Months 10	PAMELA MASON PORTER 46. Facility Name (if not hatisticino, pive street and number) 114400 Ceclar Ridge Drive 10c. Cety, Town or Location of Death Portornac 114202 Ceclar Ridge Drive 10c. Cety, Town or Location of Death Portornac 114202 Ceclar Ridge Drive 10c. Social Sacurity Number 213-42-5249 10b. Cecly Town or Location 10c. Cety, Town or Location 11 Martine Stellar 11 Martine Stellar 11 Martine Stellar 11 Martine Stellar 12 Martine Stellar 12 Martine Stellar 13 Martine Stellar 14 Ceclar Ridge Stellar 16 December Stellar 17 Stellar Ridge Stellar 18 Martine Stellar 18 Martine Stellar 19 December Stellar 19 December Stellar 19 December Stellar 10	PAMELA MASON PORTER 46. Celty name (first institution, give street and number) 114-00 Cedar R ridge Drive 104. Celty name (first institution, give street and number) 114-00 Cedar R ridge Drive 105-color glosurity number 213-42-5249 10 May 2 F					



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician E. Pulliam 24 1999 Susan July 2:20 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Silver Spring
| H Under 1 Year | H Under 24 Hrs. | 8. Date of 144 Bonifant Road Montgomery 8. Date of Birth (Month: Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□ M 2☑ F Yrs. Director 220-60-0105 Aug. 28, 1953 Maryland Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e Street and Number 10g. Citizen of What Country? 144 Bonifant Road 14. Raca - American Indian, 20905 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 2 should be filled within 72 hours after and Mental Hygiers. Is marked other than "natural", or its 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiere. College (1-4or 5+) Elementery/Secondary (0-12) 5+ School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 88 Lo Carl J. Ruths Boblick Anna 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If them 27 is m any injury or other traum ance. 144 Bonifant Road Silver Spring, Maryland 20905
lace of Disposition (Name of Dete 20c. Location City or Town, State Frederick L. Pulliam (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/24/99 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

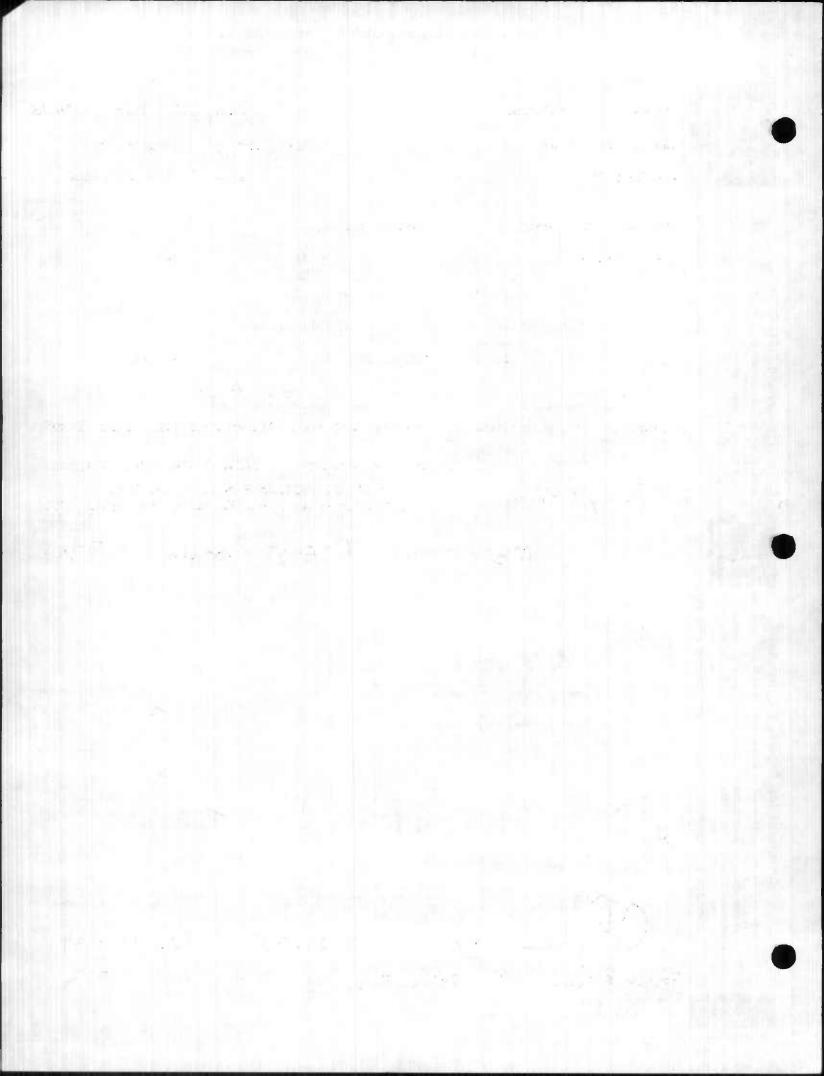
Approximate

Approximate IRACYA Stiver. Approximate Interval Between Onset and Death **Physician** Breat (man /Medical Immediate Cause (Final METASTATIL disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be axec Physician/Medicai Due to (or as a consequence of) 88 950 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. signed by t 1 Yes 2000 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peed has 1 ☐ Yes 2 DeNo 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidenca 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: 5 Pending investigation Natural 2 Accident 1 Yes 2 No death. after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) end manner as stated.

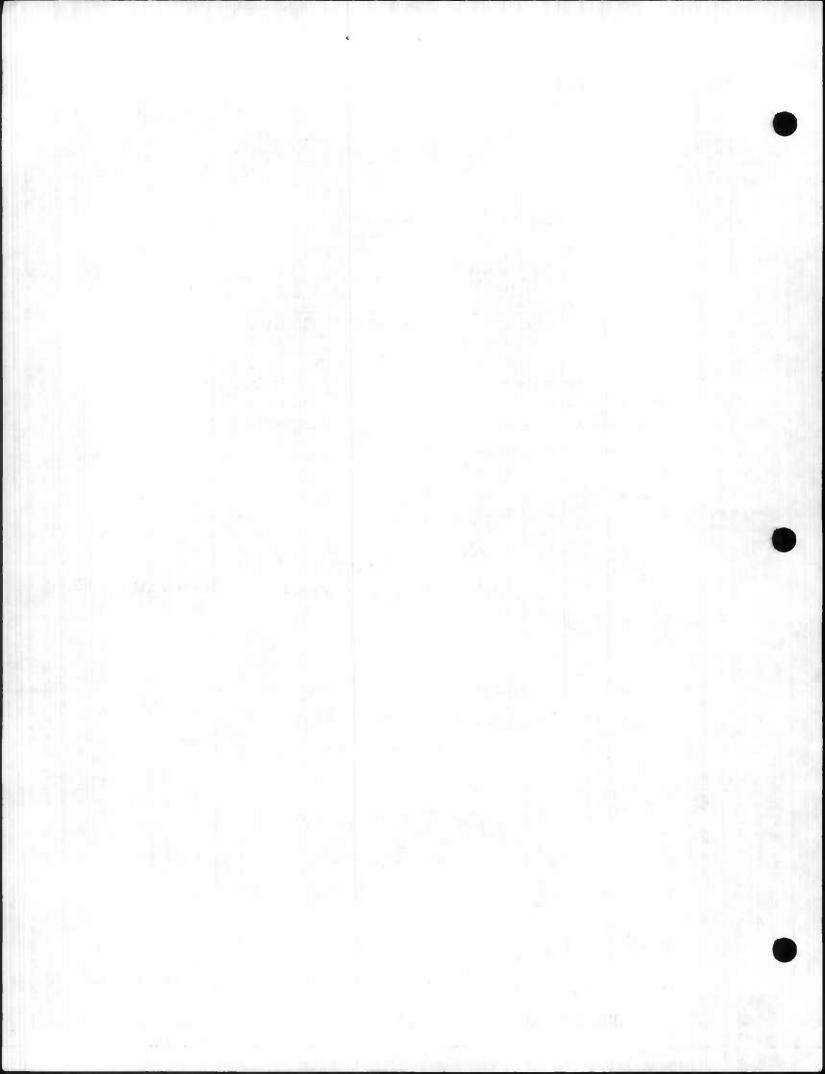
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29s. Certifie To the twithin 2 29d. Date signed (Month, Day, Year) 29b. Sign 29c. License number MD 35635 8 30 Name and address of person who completed cause of death (item 23e) (Type, Print) OLNEY, 22802 MO DR 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar

DHMH 16 Rev 6/95



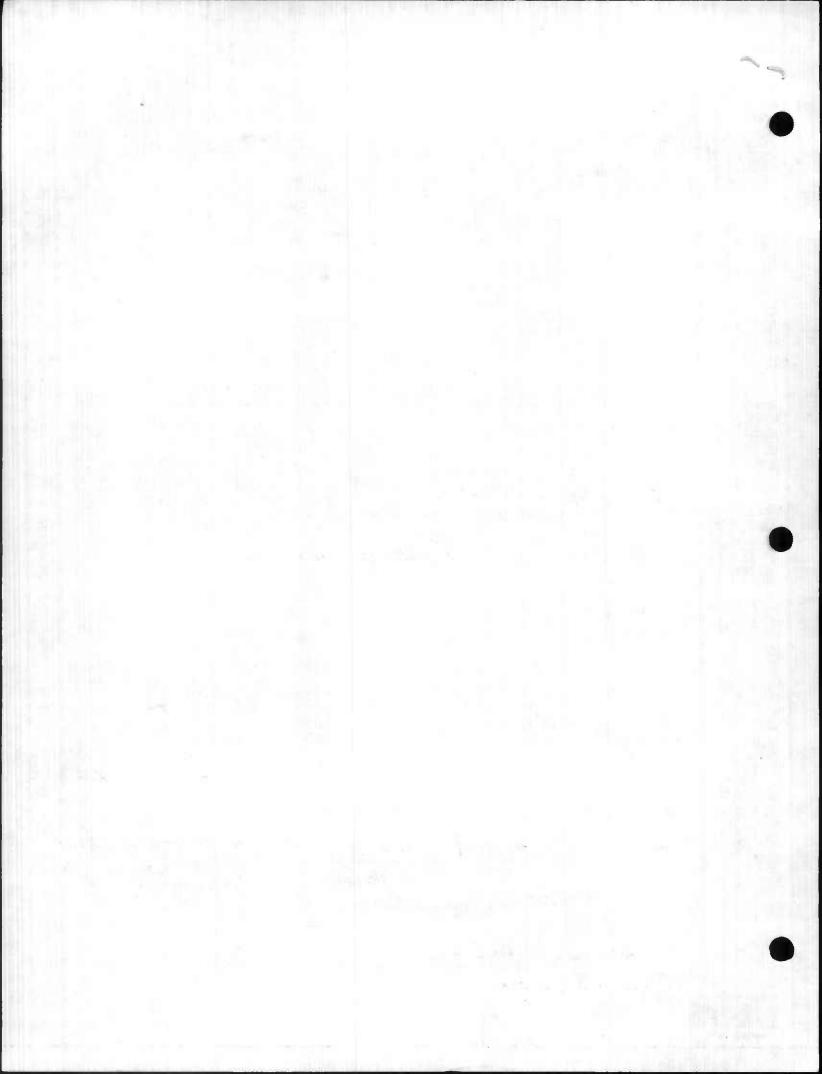
State of Maryland / Department of Health and Mental Hygiene QQ 25157

	Ce	ertificate of Death	Reg. No.	23131				
	Decedent's Neme (First, Middle, Last)		2. Date of Death Month Day Ye	3. Time of Death				
Physician /Medical	Mary R. Poole		July 24, 1999	3:50 P.M.				
Examiner	4a Facility Neme (If not institution, give street end number)	4b. City, Town, or Lo	ocation of Death 4c. County of D					
	Sunrise Assisted Living	Annapolis	Anne An	rundel				
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthde	y) If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min.	8. Date of Birth (Month, Day, Year) 9.	Birthplace (State or Foreign Country)				
Director	579-32-9481 1□ M 2Å F 80 Yrs. Usuel Residence of Decedent	MORRIS Days Frouis Mill.	Jan. 1,1919 Wa	ashington, DC				
be notified at Director	10a. Stete 10b. County 10c. City, Town or			10d. Inside City Limits				
or 28a-f s be notified Director		sonville	40- 07					
23s or unit be n	3613 Aspen Court	10f. Zip Code 21035	10g. Citizen of What	Country				
stranser m Examiner m by Fune	11. Meritel Stetus 1 Never Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, Give Yeer or Detes:	Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2XXNo Specify:	ecify Yes or No- Rican, etc.) 14. Race - A Bleck, V Specify:	Vinite, etc. White				
fical fical	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gin	cedent's Usual Occupation	16b. Kind of Busine	ess/Industry				
r, the Medical I Completed	Elementery/Secondery (0-12) College (1-4or 5+)	ve kind of work done during most of work . DO NOT use retired) memaker	Hon	ne				
O He	17. Fether's Neme (First, Middle, Last)		e (First, Middle, Maiden Sumame)					
es o Be	Edward Poore	Virgi	Virginia Fanotti					
To		uiling Address (Street and Number or Run		te. Zin Code)				
7 ls frau								
E F	20s Method of Disposition 20h Place of Dis	3 Aspen Court David	Date 20c. Location - City					
重る	1 ABurial 2 Cremetion 3 Removel from Stete	remetory or other place)						
ortant injury	4 □ Donetion 5 □ Other (Specify) Ft. Lin	1-	-28-99 Brentwood					
any in	21. Signeture of Funanal Service Licensee	22. Name and Address of Facility eorge P. Kalas Fund 973 Solomons Island	eral Home d Rd. Edgewater,	MD 21037				
been signed by the attending physician and should be detached for use as the burlet-transit up page should be detached for use as the burlet-transit up page 100 per page 100	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consecutive death)	fory Arrest sequence of): equence of):	'n diseare	12 yrs				
ysic	Part II. Other algnificant conditions contributing to death but not resulting in the	underlying cause given in Pert I.	23b. Did tobacco use contrit	oute to the cause of death?				
be detac	Ischemic ulcer	s skin	1 Ves 2 No 3	Probably 4 Unknown				
5 O	Urinary Infection	y, chronic	24a. Wes an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death?				
ege OT			1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No				
Be C	25. Was case referred to medical	26. Place of Dea!	th (Check only one)					
l director, page 2 s	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati		ome 5 Residence 6 Other (Specify/Cup min a				
= 6	27. Menner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at	28d. Describe how injury occurred	Assisted Living				
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, ferm, so building, etc. (Specify)	street, fectory, office	28f. Location (Street and Number of City or Town, State)					
y filled	29e. Certifler 1 Certifying Physician: To the best of my knowledge, der (Check only) 2 Medical Examiner: On the basis of examination and/or							
pletely fill edical	(Check only one) 2 Medical Examiner: On the basis of examinetion and/or and menner steted.	investigation, in my opinion, death occur	red at the time, date end place, and	due to the cause(s)				
Toth	29b. Signature and title of certifier	29c. License number () 2 2 0 2	29d. Dete signed (N	fonth, Day, Year)				
	30. Name and address of persen who completed cause of death (Item 23a) (Typ)	0. 0.	10056				
	1667 Chaften (later	Crytmmd.2	1114 PANER	HOOLS MD				
State Registrar	31. Date filed (Month, Dey, Year) 32. Registrer's Signeture	4 /						



State of Maryland / Department of Health and Mental Hygiene 0 0 0 1 0 0

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	1. Decedent's Neme (First, Middle, Last,					2. Date of Do Month	eath		me of Deeth		
Physician /Medical	Kevin Joe Ruchire	k				July	Dey 25	1999 01	:36 PM.		
Examiner	4a Facility Neme (If not institution, give		Route 77		4b. City, Town, or	Location of Deal	th 4c. County	of Death			
	East of Hippan Hil	.1 Road			Smiths	burg	Was	hington			
Funeral	5. Social Security Number 6. Sec	7. Age (In yrs. I		Under 1 Year	If Under 24 Hrs	8. Date of Bi		9. Birthplece (Si Country)	tate or Foreign		
Director	213-92-6208 12 Usuel Residence of Decedent	M 2□F 24	Yrs.	onths Deys	Hours Min	April 1		Marylan			
the Maryland 28a-f show notified at	10a. Stata 10b. County		, Town or Location					-	ide City Limits		
or 28a-f a be notified	Maryland Montgome	ry R	ockville						100 20.00		
Die pe	10e. Street and Number		1	Of. Zip Code			10g. Citizen of V				
an mark	801 Leverton Road			208				d States			
-0020 hours after death with the Marylar burst, or terms 23e or 28e-f show at Examiner must be notitled at cd by Funeral Director		12. Wes Decedent Ever in U,9 Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Decedent of F s, specify Cubo Yes 2 No	lispanic Origin? (5 an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	a - American Indie k, White, atc. : White	m,		
O to the De			16a. Decedent	s Usuat Occur	ation		16b. Kind of Br	ISINess/Industry			
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Merital Hyglere. 7 is marked other than "rathurst", or fraumetic event, the Medical Exam To Be Completed by 8	(Specify only highest grade Elementery/Secondery (0-12)	College (1-4or 5+)	(Give kind life. DO f	of work done NOT use retired Search	during most of wo d)	tring most of working					
C Age of O		2		45° - 14° - 14°		Company					
B state	17. Father's Neme (First, Middle, Last)		me (<i>FIRS</i>), <i>Middle</i>	e, Maiden Sumam	10)						
Via ould Member Member 10						i Kulki					
Aan and and and and and and and and and a	19e. Informent's Neme/Reletionship (Ty	pe, Print)	and Number or R	ural Route Numb	ber, City or Town,	Stete, Zip Code)					
C TO DE LA	Sermsak Ruchirek /		Road, Ro		. Maryla						
Or of the	20a. Method of Disposition 1 Burlel 2 Cremation 3 R	20b. Pi	lece of Disposition emetery, cremeto.	n (Name of ry or other plea	20) July 3	0, 1999	20c. Location -	City or Town, Ste	te		
F Page 17	4 Donation 5 Other (Specify)				orium, I						
Baltimore, emit. Pages 1 a Separiment of Hes montant: if them my injury or othe mass.	21. Signeture of Funeral Service Licensi	-	21 22. Na	me and Addre	ss of Fecility						
m acess	Vnibare In MoMile	Ver Faukence	Rober				ral Home/Rockville, Inc. nue, Rockville, Maryland 20850				
	23a. Pert1. Enter the disease, or compli shock, or heart feilure. List only or	cetions thet caused the death					ximete				
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	Due to (or	es a consequence		Snjuri	Z.A.			and Deeth		
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68760, ificate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Ceuse (Disease or Injury that initiated events resulting in death) Lest	Due to (or	es a consequenc	e of):							
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G for an an in	Pert II. Other algnificant conditions con	tributing to death but not resu	iting in the under	vina causa aix	use given in Part I. 23b. Dld tobacco use contribute to the cause of						
IS, F.O. BOX es that the death cent igned by the attendin be detached for use by Physician/M	Total agrinoun contanting con	thoung to douth out not resu	iting in the uncer	yang cause gr	COTTAL POLICE.		Yes ZENo	3 Probably			
v requir been s should							s an autopsy ormed?	24b. Were euto available p completion of death?	prior to		
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	25. Wes case referred to medical				26. Place of De	eth (Check only	one)				
hysici hysici li direc	examiner? 1 ⊠ Yes 2 □ No	ospitel: 1 Inpatient 2 E	ER/Outpatient 3	DOA Oth	an .			er (Specify) Sci	ene		
or Ph genth lead	27. Menner of Death	28a. Dete of Injury	28b. Tima of	28c. Injur		7	how injury occur		0110		
in Africant of fundamental of fundam	1 Naturel 5 Pending Investigation	7-25-99	Injury		Yes 208 No	motor	rcycle	accides	1+		
DIVISION OF VITAL He law to the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 Suicide 6 Could not be determined	28e. Placa of Injury - At hor building, etc. (Specify,)			28f. Location (City or To	(Street and Numb	er or Rural Route	Number		
l hours uneral sly filled cal Co	29a. Certifier 1 Certifying Phys	Iclan: To the best of my know	vledge, death occ	reet	ne, date and plac	e, end due to the	cause(s) end ma	nner as stated.	una(a)		
o the Hosp ithin 24 hou o the Fune ompletely fil	ane) 29b. Signeture and title of certifier	cat Examiner: On the basis of examinetion e and menner steted.		29c. Licens		one at the tille,					
	1	11/				29d. Dete signed (M					
10	Mennis	· Course no		-	C.M.E.		July	27, 1999	9		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chutem 111 Penn Street, Baltimore, Maryland 21201										
State Registrar	31. Dete tiled (Month, Dey, Year) JUL 3 0 1999	32. Registrar's Signet		loc. V	.,						



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Time of Death

Physician /Medical **Examiner Funeral**

Director Show

Directo

Funeral

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Completed

Be

the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at death with filed within 72 hours after Hygiene.

> Examiner physician and s the burial-trans Physician/Medical USB BS 0 signed by t by Completed page 2 certificata Be 2 Certification:

altimore, Maryland 21215-0020 . Pages 1 and 2 should be filt ment of Health and Mental Hi tant: If item 27 is marked oth Department important: If any injury or **Physician** /Medical **Examiner** certificate be exec Records, Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 24 hours a To the To the To the

2. Date of Deeth 1. Decedent's Name (First, Middle, Last) JULY 28, 1999 GLORIA RICHARDS 5:05 AM 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth PRINCE GEORGE'S 11601 CHERRY TREE CROSSING ROAD BRANDYWINE If Under 1 Yaar | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 M 2 KF 219-72-7420 JUNE 1, 1960 MARYLAND Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No PRINCE GEORGE'S BRANDYWINE MARYLAND 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? UNITED STATES 11601 CHERRY TREE CROSSING ROAD 20613 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Give Yaar or Dates: 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest greda completed) PRINCE GEORGE'S Elementary/Secondary (0-12) Coilege (1-4or 5+) COUNTY SCHOOLS EXECUTIVE SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) CHARLES EDWARD RICHARDS MARJORIE ALICE KIDWELL 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) DEBORAH M. HINES - SISTER 8606 UNDERMIRE COURT, BOWIE, MARYLAND 20720 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a, Method of Ulaposition Burial / 2 Demation 3 Removal from State JULY 31, 1999 CLINTON, MD 4 □ Donation 5 □ Other (Specify) RESURRECTION CEMETERY of Fundral Sprycoe Longe THE HUNTT FUNERAL HOME, INC. has 4 MARK G. BROHAWN M00053 P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Interval Between Onset and Death BREAST CANCER Immediate Causa (Final METASTATIC disease or condition resulting in death) Due to (or as a consequence of): Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants rasulting in daath) Last Due to (or as a consequenca of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy 2X No 1 Yes 1 ☐ Yas 2 ☐ No

25. Was casa rafarred to medical

1 Yes 2 No 27. Mannar of Death 1 Natural

5 Pending investigation 2 Accidant 6 Could not be detarmined 3 Suicide 4 Homicide

1 Cartifying Phyafcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated.

28e. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of 28c. Injury at Work? 1 Yes 2 No

> 29c. Licensa number D43346

26. Place of Death (Check only one)

8926 WOODYARD ROAD #201, CLINTON, MD 20735

Other: 4 Nursing Homa 5 X Rasidenca 8 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Yeer)

28f. Location (Straet end Number or Rurel Route Number, City or Town, Stata)

JULY 28, 1999

State Registrar

edical

29a. Certifier

RITA

31. Date filed (Month, Dey, Yaer)

29b. Signeture and titla of cartifier

JUL 3 0 1999

GUPTA

32. Ragistrar's Signature

1 Inpatient

28a. Date of injury (Month, Day Year)

MI

MD

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 23, JUDITH JULY RASKIN 1999 BARBARA /Medical 4a Facility Nama (If not Institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) BAL HMORP None THE JOHNS
5. Social Security Number HOPKINS 6. Sex If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1□ M 2♥ F Months Hours Min. Yrs. Minnesota 63 473-34-0472 Usual Residence of Decedent 10c. City, Town or Location 10a. State District 10b. County 10d. inside City Limits 1) Yas 2 No Director of Columbia Washington N/A 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20009 2022 Columbia Road, NW, #602 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: à White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ Writer Self-Employed 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Bellman Sally Finklestein 19a. informant's Name/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7209 Holly Avenue, Takoma Park, Maryland Jamin Ben Raskin (son) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-26-99 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Fine) disaase or condition resulting in death) moxia 7 minutes Dua to (or as a consequence of) Examine 3 Weeks ESPIRATORY FAILURE Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) SEPSIS 5 WEEKS Physician/Medical Dua to (or as a consequence of): MESENTERIC ISCHEMIA 6 WEEKS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown MYOCARDIAL INFARCTION þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yes 2 No 25. Was casa rafarred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Impatient Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28b. Time of fnjury 27. Manner of Death 28a. Dete of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and mennar es stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of curtifier 29c. License number 29d. Date signed (Month, Day, Year) 23, 1999 BALTIMORE, RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND

Funeral

Director

288-1

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Norms 23a

"natural", or

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hys Important: If Isem 27 is marked othe any Injury or other treamatic event, 9068.

Physician /Medical

Examiner

physician and the burial-transit

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filled in

24 hours after death.

Funeral Director: A

To the Hosp within 24 ho To the Fune completely fi

that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital Physician:

Division

or Attanding

Hospital

The law requires

Baltimore, Maryland 21215-0020

State Registrar JULIE

31. Data filed (Month, Day, Year)

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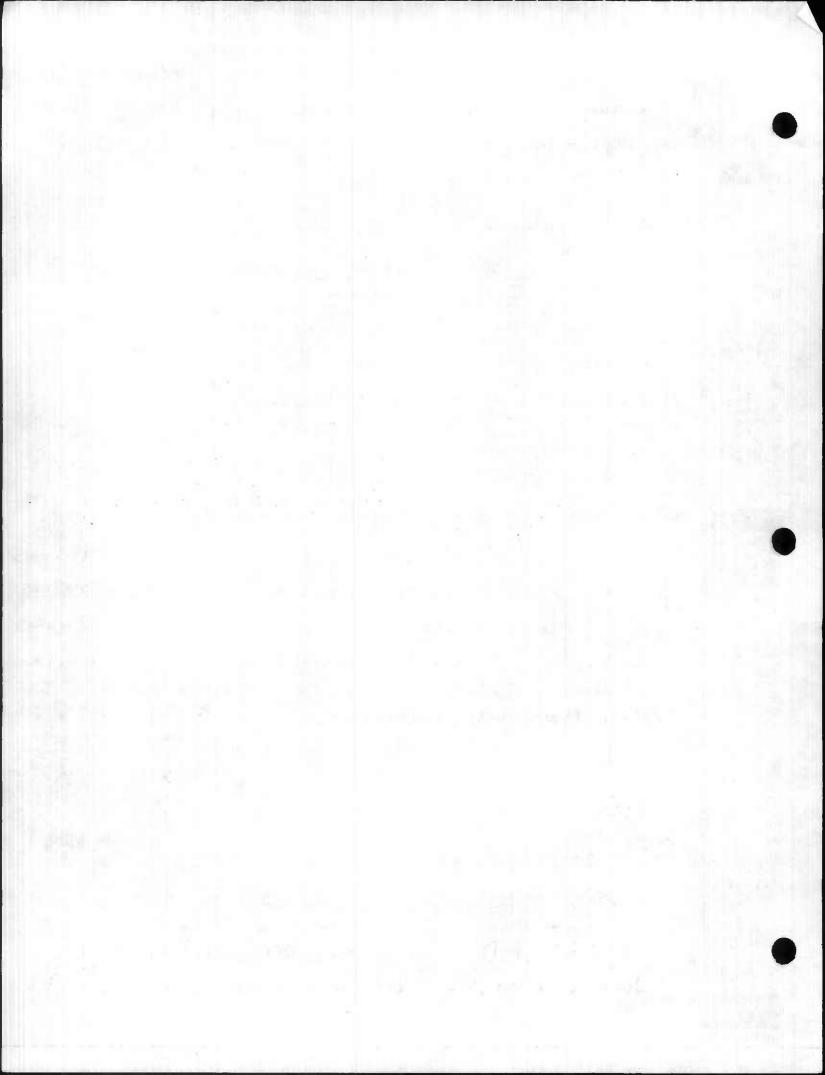
PARK MD 32. Registrar's Signature Symme

600 NORTH

WOLFE

STREET

21286-9106



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 25 | 6 |

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		_	. Decedent's Name	a (First, Middle, L.	est)							2. Date of D		A 11	Vaar	3. Time of De	ath
	Physician	_	ALBER	Т	RATHNER							Month July 2	3. 1	ay [999	Yaar	5:10 P	М
	 /Medical Examiner 		a Facility Name (I							4b. City,	Town, or Lo	ocation of Dea	-		of Death	10010	
A	LAdillile	-	Washingt	on Adven	tist Ho	enit	21			Take	ma Pa	rk	N	Monto	omer	17	
-	Funeral	_	. Social Security N		Sex	-	In yrs. last birt	hday)	If Under 1 Yaar	r If Und	er 24 Hrs.	8. Date of B				y lace (State or F itry)	oreign
	Funeral Director		77-22-82		1 ★M 2 F	7	,	Yrs.	Months Days	Hours	Min.						
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	tend	1	Oa. Stata	10b. County		1	Oc. City, Town	or Loc	ation						1	0d. Inside City I	Limits
	72 hours after death with the Meryland natural, or items 23a or 28a-f show diest Examiner must be notified at shad by Funeral Director	I	srael	None		1	Netanya	a								Yes 2	□ No
	or 28a-fa	1	Oe. Street and Nur	mber					10f. Zip Code				10g. C	itizen of \	What Coun	itry?	
	A SO		Calabana	11 - + - 1 N	n	.1	77.2. 11	0/					TT	S.A.			
	r from 23 of per man	5 1	1. Marital Status	Hotel, N	12. Was Dec				as Decedent of	Hispanic (Origin? (Sp	ecify Yes or N	-		e - Americ	an Indian.	
	ter d	3		ied 2 Married	Armed F	orces? 2 □ No		If	Yes, specify Cul	ban, Mexic	an, Puerto	Rican, etc.)			k, White,		
21215-0020	or af		3 Widowed		If Yes. G		2 1.6	1	Yas 200No	Speci	fy:		150	Specify	: W	hite	
ö	"natural",	2		15. Decedent's E		4.	168	Decede	nt's Usual Occu	nation			16b. J	Kind of Bi	usiness/inc	dustry	
15	in 72	2		cify only highest gi	ade completed			(Give k	ind of work done	durina m	ost of work	ing				,	
12	ed within 72 horygiene. For then "netural, to the Wedlest Completed		Elementery/Seco	ondary (0-12)	College 5+	(1-4or 5+)			y Concr				Cc	nstr	ucti	on	
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Maryland	Mental Harked oth		Maurice	Rathner						CI	are I	Perkiss					
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	4 9 E E	2	Jeffrey	Rathner,	Son		20b. Piace of	Dispos	ition (Name of			Date	-	-	City or To		
0	200		1 🖾 Burial 2	☐ Cramation 3 [Stata	cemeter	y, crema	atory or othar pl	ace)	7/20	6/1999					
Ħ	permit. Page Department of Important: If any Injury or once.						Eretz									srael	
Baltimore,	permit. P Departme importan any injur	1	21. Signature of Fu	ineral Service Lice	ensea n	. 0		ST	EIN HEB	REW N	EMOR!	IAL FUN	IERAI	L HON	Æ, I	NC.	
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	D) U	19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, Constitution State) 19b. Meiling Address (Street and Number or Rural Route Number, Constitution State) 19b. Meiling Address (Street and Number or Rural Route Number, Constitution State) 19b. Meiling Address (Street and Number or Rural Route Number, Constitution State) 20b. Place of Disposition (Name of cemetery, crematory or other place) 7/26/1999														Approximate Interval Between	en
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4	/Medical		mmediate Ceuse (disease or condition	(Final	Ca	Min	GOUNG	5	hock						i	Hours	2
	Examiner	-	resulting in death)		8	Di	Gene.	onsequ	ence of):							HOURS	
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ta	certificate rector, pag) 2	5. Was case refer		71.0 10	og	1200			26. Pla	ce of Deat	h (Check only	one)				
	2 00		examiner?	^C No	Hospital:	Inpatient	2 ER/Out	tpatient	3 DOA	ther: 4 🗆	Nursing Ho	me 5 Res	sidence	6 Oth	er (Specif	(y)	
10	er this seral di		7. Manner of Death		28a. Dete	of Injury	(eas) 28b. T		28c. Inj	ury at		28d. Dascribe	how inj	ury occur	red		
Division	Attending I or death. ector: After by the funer iffication		D⊡Natural 2 ☐ Accident	5 Pending investigation		nii, Day i	921/ 11	njury		Yes 2	□No						
VIS	Attendi		3 ☐ Suicida 4 ☐ Homicide	6 Could not I	289. Plac			rm, stre	et, factory, office						per or Rura	I Route Numbe	IF,
ă	to or Attending P is after death. In Director: After the in by the funeral Certification:		4 Homicide		DUIIC	ding, etc. ((Specify)				_ //	City or To	JWII, SIE	10)			
	replit hours		29a. Certifier	1 Certifying P													
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification		(Check only one)	2 Medical Exa		pesis of ex nner stete		d/or Inve	stigation, in my	opinion, d	eath occur	red at the time	, date ar	nd place,	and due to	the cause(s)	
	To the To the Somp		9b. Signatura and	title of certifier					29c. Licer	nse numbe	٦		29d. D	ete signe	d (Month,	Day, Year)	
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	State	3	11. Date filed (Mont	oth, Day, Year)			Signature	arro	A AVEI	ide,	Darre	400,	Lakul	ma F	TING	110 2071	_
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State of Maryland / Department of Health and Mental Hygiene 🚨 🔾

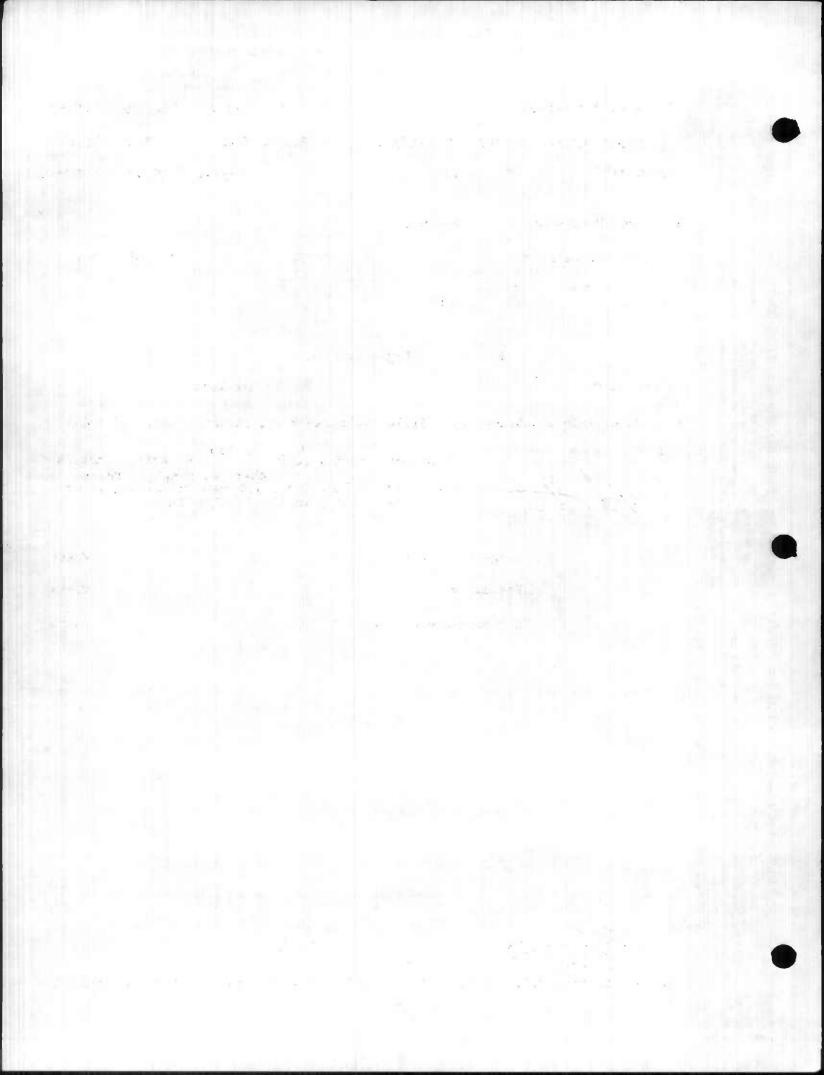
Certificate of Death 3. Time of Death 1 Decedent's Nama (First Middle Last) 2. Data of Death Month **Physician** July Neoma A. Reidenbach 1999 23, 20:53 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours Min 1□M 2₩F Yrs 579-40-3328 75 Director August 26, 1923 North Dakota Usuai Rasidance of Decedant with the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified as 1 ☐ Yas 21 No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 11710 Smoketree Road 20854 Funerai United States should be filed within 72 hours after death 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Raca - Amarican Indian Black, Whita, atc. 1 ☑ Yas 2 ☐ No
If Yas, Giva
Yaar or Datas: WWII 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16h Kind of Business/Industry and Mental Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) Hospital Registered Nurse 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Joseph Thorne Cecile Morrison 2 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Peges 1 and 2 sh Department of Health and Important: If Itam 27 is m any Injury or other traum once. Richard R. Reidenbach/Husband 11710 Smoketree Road, Potomac, Maryland 20854 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) July 27, 1999 20c. Location - City or Town, Stata 20a Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Pumphrey Funeral Home/ 21. Signature of Funeral Service Lice 22. Nama and Addrass of FacilityRobert A. Rockville, Inc., 300 West Montgomery Avenue, M01126 Rockville, Maryland 20850-2805 the disease or compliantons that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. Ust only one cause on each line. Intarvai Between Onset and Death **Physician** Immadlata Causa (Final disaasa or condition rasulting In daath) /Medical Congestive Heart Failure Weeks Examiner Dua to (or as a consequence of): Examiner Pneumonia Weeks ician and buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last Dua to (or as a consequence of): certificate be exec Box 68760, Cerebrovascular Accident Years physician Physician/Medicai the Dua to (or as a consaquanca of): 98 950 for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o. eyl detached 1 Yee 2 No 3 Probably 4 Unknown نے Records, ģ 8 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed been completion of cause of death? page 2 certificate has 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Physician: 25. Was casa rafarred to madical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) P 1 Yes 2 No 1 ₺ Inpatiant 2 ☐ ER/Outpatient 3□ DOA Aftar this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 28b. Tima of 5 Panding Invastigation Hospital or Attending 1 Naturai aftar death. 1 Yas 2 🗆 No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) filled in by 4 ☐ Homicida 24 hours a 29a. Cartifiar t 🖸 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and piaca, and dua to tha causa(s) and mannar as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. within 2 the th 29b. Signature 29c. Licansa number 29d. Data signed (Month, Day, Yaar) D35792 July 24, 1999 10+1 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) 50 W. Edmonston Drive #504, Rockville, Maryland 20852-1228 Swaroop G. Rao, M.D. 31. Data filad (Month, Day, Yaar) 32. Reflistrar's Signatura oaks

DHMH 16 Rev 6/95

Registrar

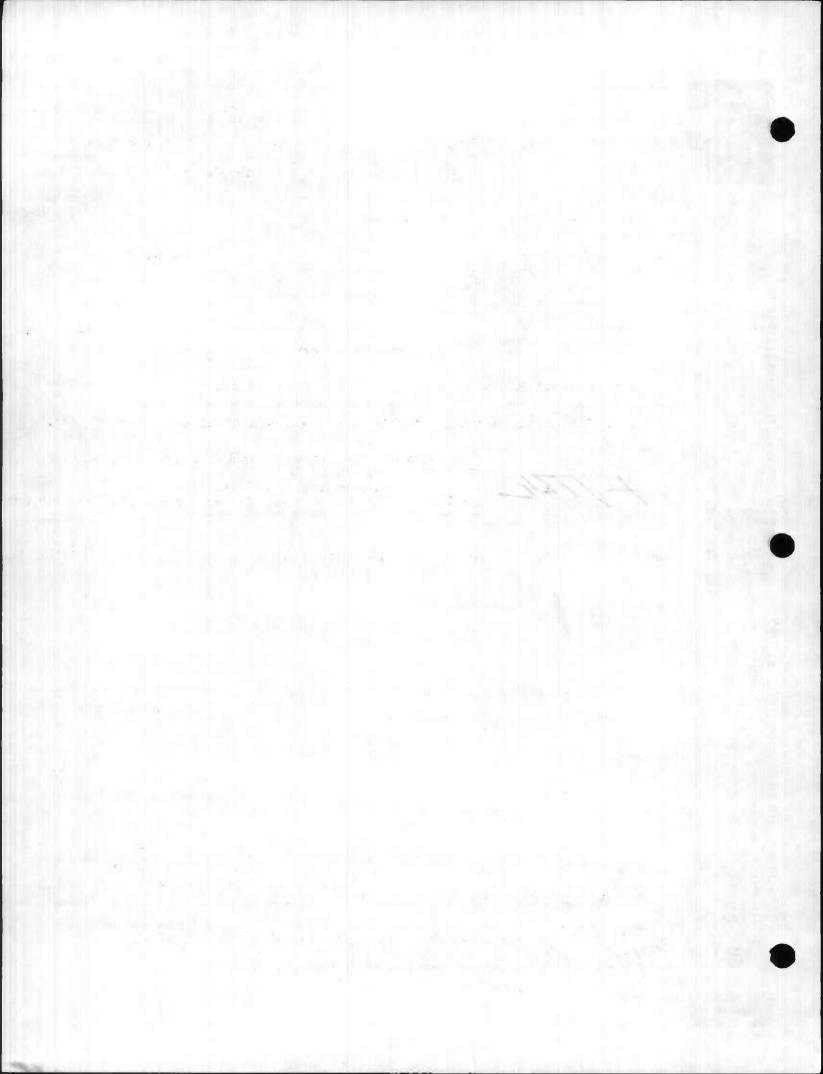
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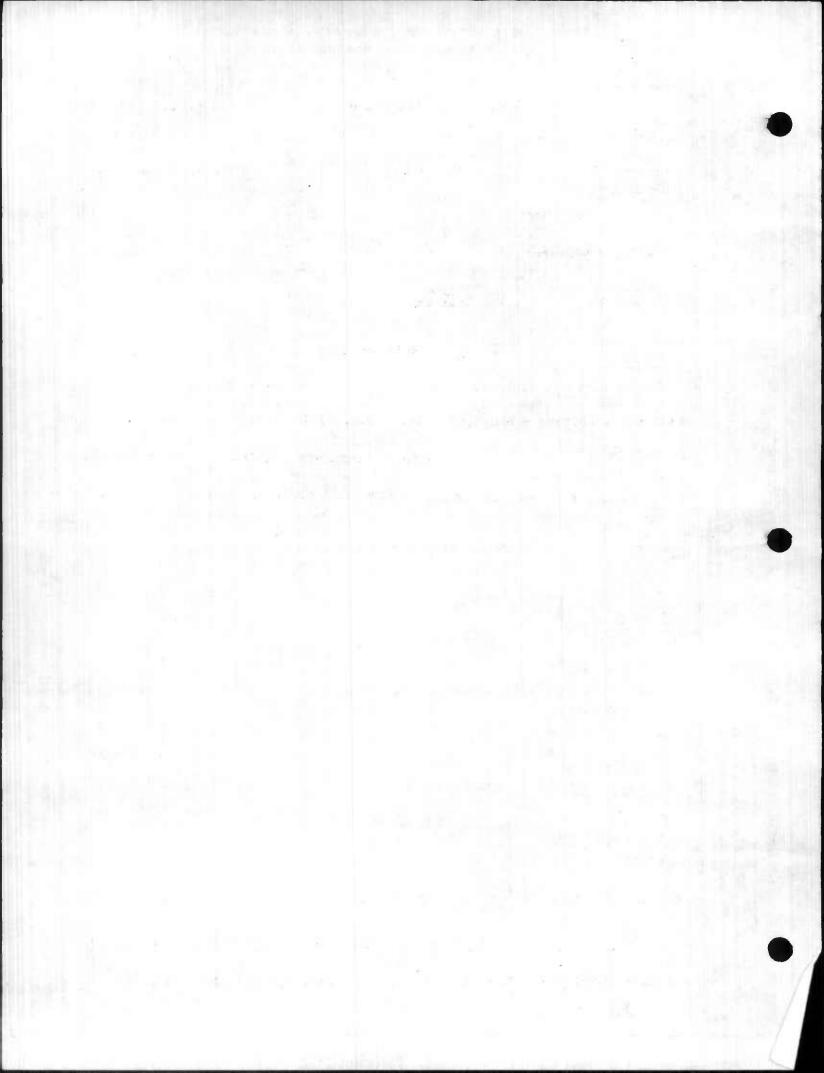
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	Decedent's Name (First, Middle, Las	Al	С	ertificate of	Death	2. Date of De	Reg. No.		3. Time of Death					
Physician	Anne Francis	" Richard	lson			Month July 20	Dey	Yeer						
/Medical Examiner	4a Facility Nama (If not Institution, give		-		4b. City, Town, or L			of Deeth	7:40 p.m.					
Examiner	Prince George's H		nter		Chever1y		Princ	e Geo	rge's					
Funeral	5. Social Security Number 6. Se	7. Age (I	In yrs. lest birthd	ay) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, De	th Year)							
Director	011-28-7333	□M 2X)F	69 Yrs	. Months Days	Hours Will.	December	5, 1929	Rhod	e Island					
D .	Usual Rasidanca of Dacedant 10a. Stete 10b. County	10	Oc. City, Town or	Location				10	Od Inside City Limits					
anyla danyla	Maryland Prince G		Mitchel						1 ☐ Yes 2 No					
or 28a-f s be notified Director	10e. Street and Number	00180	112 001101	10f. Zip Code			10g. Citizen of V	What Count	trv?					
N S S S S S S S S S S S S S S S S S S S	10450 Lottsford R	oad		20721										
r items 23s	11. Meritel Stetus	12. Was Decedent Eve	er in U,S. 1	3. Was Decedent of I If Yes, specify Cub	Hispenic Origin? (S	pecify Yes or No		e - America	an Indian,					
Trictious electionarity minima maryland "naturel", or items 23s or 28s-f show added Examiner must be notified leted by Funeral Director	1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No		Hican, etc.)		,						
ted by	15. Decedent's Ed	ucation	16a. De	cedent's Usuel Occu	petion	Lina	16b. Kind of Bu	1999 7:46 4c. County of Deeth Prince George's 9. Birthplece (Stete or County) 1929 Rhode Islan 10d. Inside City 1						
	(Specify only highest grad	College (1-4or 5+)		ive kind of work done e. DO NOT usa ratire		King		Profit Education of Town, State, Zip Code) Maryland 20721 Maryland 2073 Maryland 2073 Maryland 2074 Maryland 2075 Maryland						
Hygiene. ther ther ent, the		4	Vol	unteer Lea	1				ndamental					
Se se	17. Father's Name (First, Middle, Last)	4 11 1			18. Mother's Ner			10)						
T ST	Thomas Pierrepoin		1		Anne Fr		•	0	0.71					
T Is m	19e. Informent's Neme/Ralationship (7) Elliot Lee Richar													
Item 27	20e. Mathod of Disposition		20b. Plece of Di	sposition (Neme of		Dete		_						
int: if its	1 ☐ Burial 2 🖾 Cremation 3 ☐			cremetory or other ple		7/28/99	Roltevil	Maryland 20721 on-City or Town, Stete lile, Maryland Maryland 2091						
Important: any injury once.	4 Donetion 5 Other (Spacify) Chesapeake Crematory 7/28/99 Beltsville 21. Signature of Funeral Service Liberts 2													
Important: If It any injury or once.	Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 2093													
	23e. Part1. Enter the disease, or comp			enter the mode of dy	Ing, such es cardiac	or respiratory e	orrest,	Maryı	Approximete					
ysician	23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.													
ledicai	Immediate Cause (Final disease or condition resulting in deeth) e. Aspiration Pullmonta Due to (or as e consaquanca of):													
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physician and s the burial-transit edical Examir	Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as e con	saquence of):				1						
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edical	resulting In deeth) Lest	Du	e to (or as e con	sequanca of):										
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ad for	Pert It. Other significant conditions co	entributing to death but n	not rasulting in th	a underlying cause gi	iven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?					
ed by the attending detached for use a detached for	All	us De	,	i		1	Yes 20XNo	3 Prob	bably 4 Unknown					
bed by	MIJNEW	NIS CHO	III											
page 2 should l							an autopsy ormed?	ava	alleble prior to					
has b ge 2 st														
rector, page						120	Yes 2□No	1	Yes 2 No					
Be Be	25. Was case referred to medical examiner?	Hasaital:			26. Plece of Dec	th (Check only	one)							
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funer funer flon:	27. Mannar of Death 1 Neturet 5 □ Panding	28e. Dete of Injury (Month, Day Y	ear) 28b. Tim Inju	ry Wo	ork?]Yes 2 ☐ No	∠ou. Dascribe	now injury occur	190						
led in by the funeral Certification:	2 Accident Investigation 3 Sulcide 6 Could not be	28e. Place of Injury	- At home form	street, factory, office		28f. Location	Street and Numb	ber or Rura	l Route Number.					
dinb	4 ☐ Homicide datarminad	building, etc. (Specify)	, enough rectory, onlos		City or To	wn, Stata)							
Medical Certification: To Be (29a. Certifier Check only one) Check only	relcian: To the bast of n iner: On the basis of ex and mannar stated	aminetion end/o	aeth occurred et the ti r Investigation, in my	ime, dete end plece opinion, deeth occu	, end due to tha rred et the time,	causa(s) and ma dete and ptaca,	annar as st and dua to	ated. the causa(s)					
To the Funeral Completely filled	29b. Signature and title of certifier	1) 1		29c. Licen	se number		29d. Date signe	d (Month, I	Day, Year)					
	> /1/1// /	1/16	MO	194	7603		07/261	199						
	30. Name and address of person who o	omplated cause of deet	h (Item 23e) (Tu	pe. Print) (1) Mi	AM CAR	1110	- 1,00/)						
	30. Nama and address of person who completed causa of daeth (Item 23e) (Type, Print) WIMAM F. Duboyce, MO													
State	31. Dete filed (Month, Day, Yaar)	32. Ragistrer's	Signetura	00/19										
State Registrar			Signetura	1 /	,									



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State of Maryland / Department of Health and Menta	I Hygiene	9 2	5	51	1
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hysician					Ce	rtificate	OI L	Jeatn			Reg. No.			
nysician	1. Decedent's Nam	a (First, Middle, Le	ist)							2. Date of De Month	ath Day	Year	3. Tima	of Death
/Medical			George		Rich	ardson		4916		JULY	21, 1		:05	PM
xaminer			ve street and number Medical		er	-		Tov	WS OT	ocation of Death	,	of Death altir	nore	
neral ector	5. Social Security N 578-44-4	415	Sex 7. A 1⊠ M 2□ F	ige (In yrs. 65	last birthday, Yrs.	Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Oct. 3(, Year) 933	9. Birthpl Count IOWa	ace (State iry) L	or Forei
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nine must be notified Funeral Director	10e. Street and Nur 28 Alleg	heny Ave	nue			10f. Zip C	ode	212	204		10g. Citizen of I	What Count JSA	try?	
by	11, Marital Status 1 Never Marri 3 Widowed	ed 2 Merried 4 Divorced	12. Was Deceden Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates	? No Kor	ea	Was Deceder If Yes, specify 1 ☐ Yes 2√		spanic Origin, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)	Ble	4. Race - American Indian, Bleck, White, etc. Specify: White		
ete firm	(Spec	15. Decedent's E	ducation ade completed)		(Give	dent's Usual (done d	uring most	t of work	ing	16b. Kind of B	usiness/Ind	ustry	
Completed	Elementary/Seco		College (1-4or	5+)	life.	DO NOT use	retired)				11 0	A 2000		
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To Be			n Richards	on						Downe				
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ury or other t	20a. Method of Disposition 1 Buriel 2 **DCremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cernetery, crematory or other place) National Crematory 7/27/99 Fal								Falls			7A		
any injury	21. Signeture of Fu	nerel Service Lice	nsee	· Lo		2. Name and					wler's		20	016
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Examiner	resulting in death) Sequentially list co	nditions,	b		r as a conse							1		
Medical	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) in		c	Due to (or	r as a consec	quence of):								
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d be detached for used by Physician/	RENAL	FAILURE	194							10	Yes 2 No	3□ Prob	ebly 4	☑ Unkno
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fune	27. Manner of Death 1 Netural 2 Accident	5 Pending investigatio		ay Year)	28b. Time of Injury	M 280	Work	es 2 □	No		how Injury occur			
ed in by	3 ☐ Suicide 4 ☐ Homicide	determined	286. Place of If	njury - At ho dc. (Specif)		reet, factory, o	office			28f. Location (: City or To	Street and Numi vn, State)	ber or Rura	l Route Nu	ımber,
completely filled in by the	29a. Certifier (Check only one)	1 Certifying Pt 2 Medical Exam	nysician: To the best miner: On the basis of and manner s	of examinat	wledge, deat tion and/or in	th occurred at evestigation, in	the tim	a, date en inion, dee	d place, th occur	and due to the red at the time,	cause(s) and m dete and place,	anner as sta	ated. the cause	ə(s)
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Examinei		a Facility Name (If not instituted PRINCE GEORGE!						CHEVERLY	Dation of Deal	PRINC		RGE'S
uneral irector	5	5. Social Security Number	6. Sex 1)XIM 2□ F	7. Age (In yr.	s. last birth	day) If Under Months	1 Year Days	If Undar 24 Hrs. Hours Min.	8. Date of Bi (Month, Di JAN . (ly, Year)	9. Birthple Count EL S.	ce (State or Fore
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at be no		3104 HENDERSON	AVENUE			10f. Zip				10g. Citizen of V		y?
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"naturel", pures Exp			nt's Education		16e. [Decedent's Usua	l Occup	atlon		16b. Kind of Bu		
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tem 27 is other treu		VICTOR M. RODR 19a. Informant's Name/Relation			19h	Mailing Address	/Street	MARIA MC		er City or Town	State Zin	Code)
		GEORGE A. MOLI		ER)				N AVENUE				
		20a. Method of Disposition 1 Burial 2 Cremation 4 Donetion 5 Other (3 □Removal from	n State	Place of I	Disposition (Name, cremetory or o	ne of ther pla	ce)	Date UL.26,	20c. Location -	City or Tov	
Important: If I any Injury or once.		21. Signature of Furneral Service Liegnsea 22. Name and Address of Facility HINES-RINALDI FUNERAL 11800 NEW HAMPSHIRE A SILVER SPRING MARYLAN										
		23a Party Enter the dinease, o shoot, or heart failure. Lis	r complications that	cased the de	ath. Do no	ot enter the mod	e of dyle					Approximate Intarval Between Onset and Death
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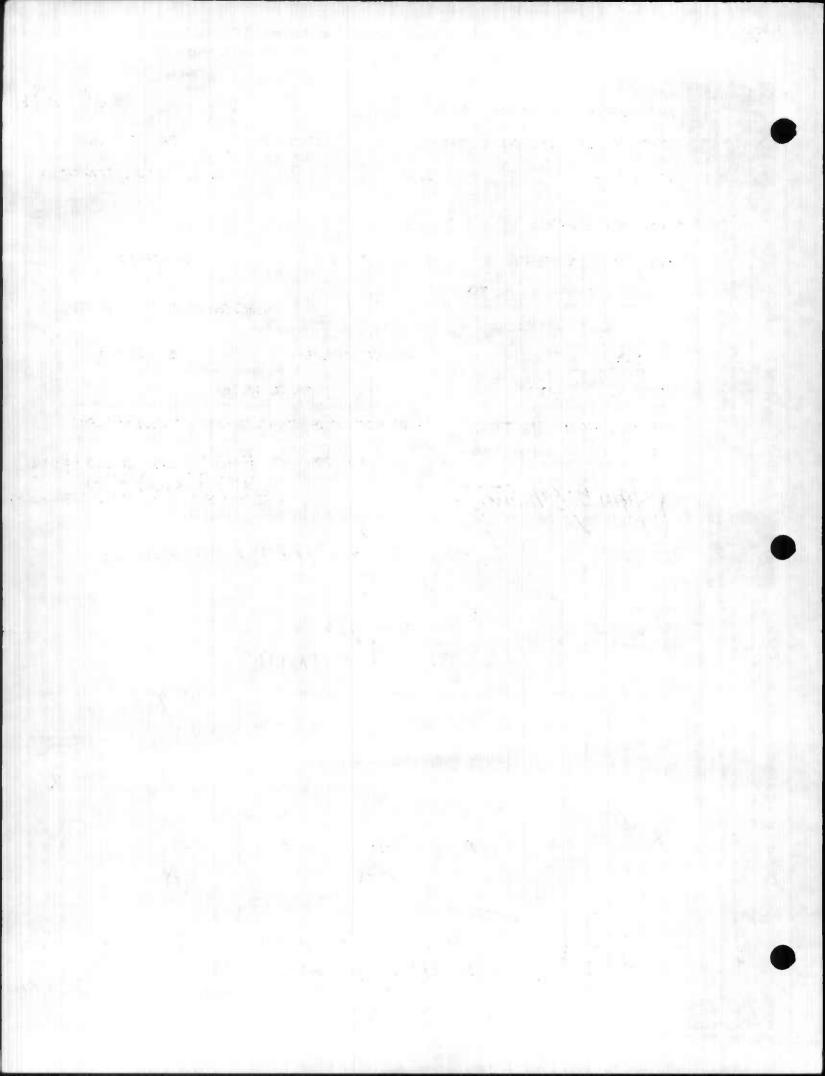
State Registrar

31. Date filed (Month, Day, Year) JUL 2 6 1999

30. Name and address of

32. Registrar's Signeture

License number 420



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 25/66 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death - Month RUB, J 12:40 -PETER-75 1999 24 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days 1X) M 2 F Hours 89 577-18-8983 Feb. 25, 1910 New York Usual Residence of Decedent 10e State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4750 Chevy Chase Drive #201 20815 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) t 4. Race - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) salesman/manager Hecht's Company 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) unavailable Mary unavailable 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda I. Rubin/daughter 2702 Wisconsin Ave., N.W. #104, Wash., D.C. 20007 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State Dete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) King David Memorial Park | July 28,99 Falls Church, Va. 21. Signeture of Furtherel Service Licenses 22. Neme end Address of Fecility DeVol Funeral Home 2222 Wisconsin Ave., N.W., Washington, DC 20007 ner the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, in heart failure. List only one cause on each line. Approximata Intervel Between Onset end Death Immediate Cause (Final 564511 disease or condition resulting in death) Due to (or es a consequence ot): to PWIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): s dysplastic Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2DENO 3 Probably 4 Unknown 24b. Were sutopsy findings aveilable prior to 24e. Was en autopsy performed? completion of cause of death? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpalient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Examiner Physician/Medical Examiner physician and the burial-transit law requires that the death certificate be 80 USB þ Completed certificate has b Division of Vital Be To this Certification: death. 24 hours after deat Funeral Director: 6 To the Hosp within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Funeral

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permit. Pages 1 and 2 ahould be life.
Department of health and Mental Hygh
any linjury or other.

Physician /Medical

Baltimore, Maryland 21215-0020

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25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Westures 2 ☐ Accident 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) 24,

Jvy

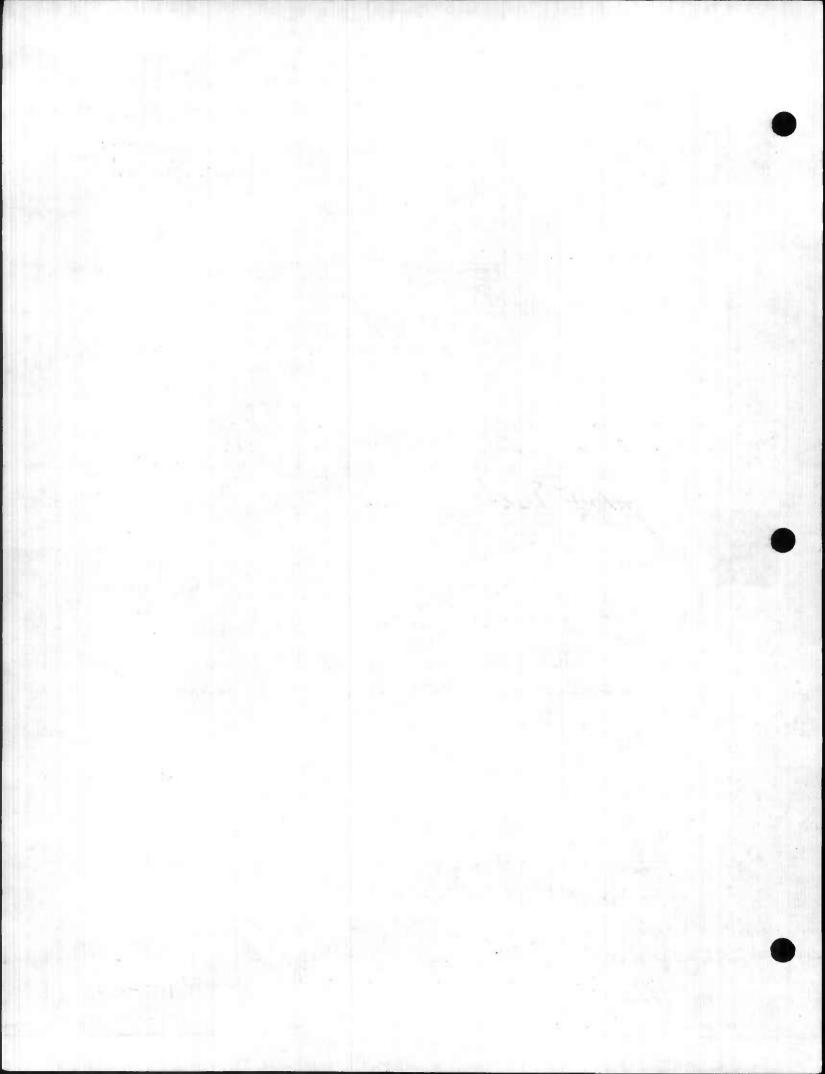
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 25 167

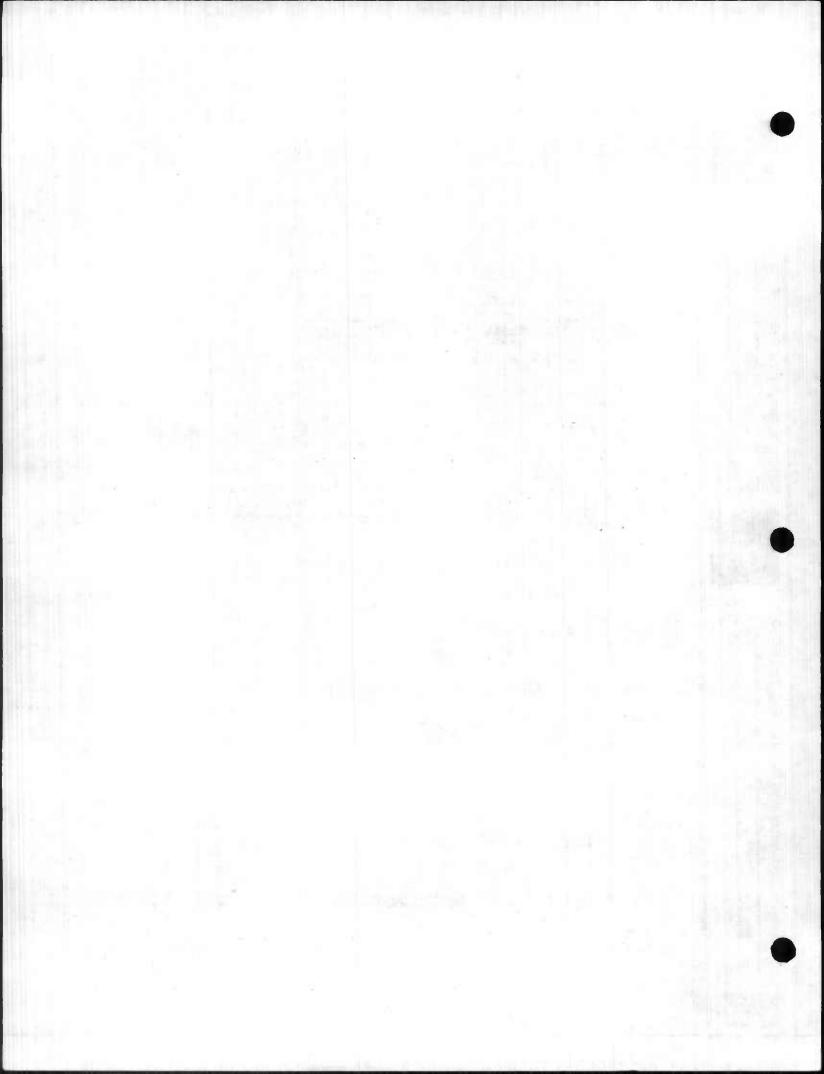
	Cer	tificate of Death	Reg. No.	20101			
	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death			
Physician /Medical	Edward Francis Ryan		July 25, 1999	12:40PM			
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death 4c. County of	f Death			
	Anne Arundel Medical Center	Annapol	is Anne A	Arundel			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Birthplace (State or Foreign Country)			
Director	577-14-3375 1∑ M 2□ F 83 Yrs. Usual Residence of Decedent			Colorado			
Manylan f show led.st	10a. Stele 10b. County 10c. City, Town or Loc Maryland Anne Arundel Annapol			10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
or 28e-f to 28e-f be notifie	10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	nat Country?			
	8205 Rivercrescent Drive	21401	United St				
020 un after death v aft, or hems 23s Examiner mast by Funeral	1 Never Married 2 Married 1 Noves 2 No. 2 / 5 / 44	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 Xuo Specify:					
1 21215-0020 ed within 72 hours at typiere. we than "netural", or it, the Medical Exam Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b. Kind of Busi	iness/Industry			
The state of the s		er/News Director	News Med	Media			
	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)				
Maryland 2 should be file 42 should be file h and Mental Hy 7 is marked othe To Be (Willis T. Ryan	Margaret	Turner				
A STATE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN C		g Address (Street and Number or Run		tate, Zip Code)			
M od 2	Lois Richardson Ryan (wife) 8205	Rivercrescent Dr.	Annapolis MD	21401			
13 5 C	20a Method of Disposition 20b, Place of Dispos	sition (Name of		city or Town, State			
D September 19	1 Li Burial 2 Li Cremetion 3 Li Removal from State	atory or other place)	/00 P	a Manadana			
Baltimor permit Pages Department of timportent if the eny injury or of	I C. Dinoc	In Crematory 7/28 Neme and Address of Facility John		d, Maryland			
Depa Depa Depa Buy in poor	Developm Dailey 14	7 Duke of Glouces	ter St. Annapoli	is, MD 21401			
Physician	23a. Part1. Enter the disease, or compolications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death			
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Cerebral	Intarction	1	Immed			
executed in and international texaminer	0.	erebrovascul	an disease	Years			
38760, cate be executed physician and the burial-transit edical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Alanschens	rsclores Yrs				
0 5 5 9	that initiated events resulting in deeth) Last	pence of): Dichetes	malliTus	Yrs			
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.O. Bo	Part II. Other algorificant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23b. Did tobecco use cont	ribute to the cause of death?			
P. Hat the had	HyperTension		1 ☐ Yes 2 ☐ No 3 ☐				
require require should			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
The law rate has page 2			1□ Yes 2□No	1 ☐ Yes 2 ☐ No			
vicien: The certificate rector, pag	25. Was case referred to medical	26 Place of Deal	th (Check only one)				
Of Vital Physician: The Physician: This certificate ral director, page Cc.: To Be Cc.	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	Other	ome 5 Residence 6 Other	(Specify)			
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Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	281. Location (Street and Number City or Town, State)	r or Rural Route Number,			
To the Hospital within 24 hours To the Funeral completely filled Medical C	29a. Certifier (Check only one) (Check o						
To the within To the	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)			
	Jose p Frend	017965	1/25/	99			
	30. Name and address of person who completed cause of death (from 23a) (Type, F	5 Adgely F	the Annan	Vis, my.			
State	31. Date filed (Month, Day, Veer) 32. Registrar's Signature	Son V	0	21401			

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State of Maryland / Department of Health and Menta	I Hygiene 9	2	51	6	8
Certificate of Death	Reg. No.				

					Cer	tificate of	Death		Reg. No.				
		1. Decedent's Neme (First, Middle	e, Last)					2. Date of D		Year	3. Time of Death		
Physic		Christine E. S	alomon					July 2	Dey 23, 1999	Tear	3:10 pm		
/Med Exami		4e Facility Neme (If not institution)	_		4b. City, Town, o			of Deeth			
LAdilli	Her	Genesis Elderc	awa Tarrhill	1 Conto			Cilvon C		Monto				
		5. Social Security Number		ge (In yrs. last		If Under 1 Year	Silver S		Montgo				
Funeral			1 M 2 F		Yrs.	Months Deys		n. (Month, D	ey, Year)		place (State or Foreign intry)		
Director		579-26-9946 Usuel Residence of Decedent	*	84	,,,,,			Feb. 2	5,1915	Penn	sylvania		
P		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits		
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3 74	ct	Maryland Montgo	mery	Silve	r Sp	ring					40		
with the Marylar a or 28a-f show be notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	intry?		
death with the Maryland res 23e or 28e-1 show r.mat be notified at		806 Guilford St	•			20901			USA				
	Funeral	11. Maritel Stetus	12. Wes Decedent Armed Forces		13. V	Was Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N	0- 14. Rad		can Indien,		
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of 2 should be liled within 72 hours at the sort Mertal Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exam.	by	3 Widowed 4 ☐ Divorced	Yeer or Detes:			I□ Yes 2√√ No	Specify:		. Specif	Whit	e		
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Hand Hand		17. Father's Name (First, Middle,	Last)		Home	manel	18 Mother's No	eme (First, Middle					
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1 Mer	5	Michael Carcais					Marie C		1.0 le Number, City or Town, State, Zip Code)				
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and 2 ealth a n 27 ts		Elaine J. Lanca	ster / Daug				Street,	La Plata	Y				
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_		· yue p	you we	20						Sprir	ng, MD 2090		
		23a. Pert1. Enter the dispusse, or shock, or heert faiture. List	one cause on each i	ed the deeth. D iine.	o not ente	er the mode of dy	ing, such as cardi	ac or respiratory	arrest,	1	Approximete Interval Between		
Physician										1	Onset end Deeth		
/Medical		Immediate Ceuse (Finel disease or condition resulting in death) a Sepsis											
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certificate be executed ding physician and ise as the bunal-transit	Examinet	Sequentially list conditions	1										
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ysician: The s certificate director, pag	B	25. Wes case referred to medical exeminer?	Hospitel:			0		eeth (Check only	one)				
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	 0	27. Manner of Deeth 1 ☒ Netural 5 ☐ Pendin	28e. Dete of Inju	ey Year) 28b	. Time of Injury	28c. Inju	iry st ork?	28d. Describe	how injury occur	red			
6 6 5 9	at	2 Accident investig	etion			M 1	Yes 2□No						
or Attendate death Director: / d in by the f	E S	3 Suicide 6 Could r 4 Homicide determ	load 206, Piece of In	jury - At home, tc. (Specify)	førm, stre	eet, fectory, office	0		(Street end Num wn, Stete)	per or Rur	ral Route Number,		
d Die	Certification:		ounding, o	to. (Specify)				0.17 0.170	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
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thin of the	Me	29b. Signeture and title of certifier	14107-1410	. 1	^	29c. Lican	se number		29d. Dete signe	d (Month	Day, Year)		
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10		- VVI MON	- 5	10116		7	TUAL	20	July	24	, 117		
		30. Name and address of person	who completed cause of	death (Item 23s) (Type, I	Print)			U				
		Wilkinson J. N	linala 34	4 Unive	rsit	y Blvd.	#113, Si	lver Spi	ring, MD	2090	01		
St	ate	31. Dete filed (Month, Dey, Year)	32. Regist	rar's Signeture		, -							
Regist	rar	JUL 2	7 1999	repeva	E	1. doa	Us/						



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1999 July 23, 1:20 PM SCHACHTER /Medical 4b. City. Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Hebrew Home Of Greater Washington Rockville Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days 1 □ M 25 F Yrs. **Director** Oct. 16, 1914 Poland 377-03-1975 84 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show edical Examiner must be notified at 1 Vea 2 □ No Directo Maryland Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20852 U.S.A. 6121 Montrose Road permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23 any injury or other traumatic event, the Modical Examiner must Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, apecify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 25 Married ω Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry Elementary/Secondary (0-12) Coilega (1-4or 5+) Cashier Clothing Store 17. Father'a Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Bessie Feldman Louis Greenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7629 Fontaine Street, Potomac, Maryland 20854 Robert Schachter, Son 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Judean Memorial Gardens 7/27/1999 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service License Takoma Funeral Home, Inc. 254 Carroll Street, NW, Washington, DC 20012 Pert1. Enter the disease, or commications thet and add the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart failure. List only one cause on a per line. Approximata Intervel Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in daath) /Medical BRONCHOPNEUMONIA, BILATERAL
Due to (or as a consequence of): 1 WEER Examiner Examiner CHRONIC BRONCHIECTASES OF LOWER LOBES physician and the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immediate ceusa. Entar Undarlying Causa (Disease or Injury that Initiated avants resulting In death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 950 signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2N No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to been si Completed 24a. Was an autopsy performed? completion of cause of death? certificata has b lirector, page 2 s 2X No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only ona) 1 Yas 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending invastigation aftar death. Director: Aft 1 Tes 2 No 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, atreat, factory, office building, etc. (Specify) 3 4 Homicide filled in Hospital 24 hours 29a. Certifier 1 💆 Certifying Physician: To tha bast of my knowladga, daath occurrad at tha tima, date and piace, and due to tha cause(s) and manner as atated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of pentified 29c. License number 29d. Dete signed (Month, Dey, Year) 18084 30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print) Lockvilly MD 20852 M'D MON TRUSE 6121 31. Data filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

1999

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Month Physician** 10:55 AM SHIRLEY SCHNEIDER 27, 1999 JULY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY **BETHESDA** SUBURBAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 6, 1907 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours NEW YORK 10M 20F 91 Director 263-42-6970 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or Nama 23a or 28a-f ahor the Medical Examinar must be notified at 1 Yes 2 □ No Directo MARYLAND MONTGOMERY BETHESDA 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 5225 POOKS HILL ROAD #1713N 20814 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER permit. Pages 1 and 2 should be filed in Department of Health and Mentel Hygie Important: If Item 27 is marked other any Injury or other traumade event. In 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS RUMBERG ANNA "INKNOWN" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5225 POOKS HILL RD. #1713N-BETHESDA, MARYLAND 20814 CORALIE RICHARDS (DAUGHTER) 20h Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation / 3 ARer NEW MONTIFIORE CEMETERY 8/1/99 PINELAWN, NEW YORK 4 Donation 5 Other (Specify) 21. Signature of Funeral Service L 22 Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Pneumonia disease or condition resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the bure Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Vinknown Heart Failure Division of Vital Records, by 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Atherosclerotic Coronary Artery Disease peed Mellitus Diabetes 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) P this 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Director: After 1 DNatural or Attending 1 Yes 2 No death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Completely filled 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 53244

State Registrar

31. Date filed (Month, Day, Year) 3 0 1999

Katharine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lillie MD, 11140 Rockville Pike #348, Rockville, MD 20852 32. Registrar's Signature

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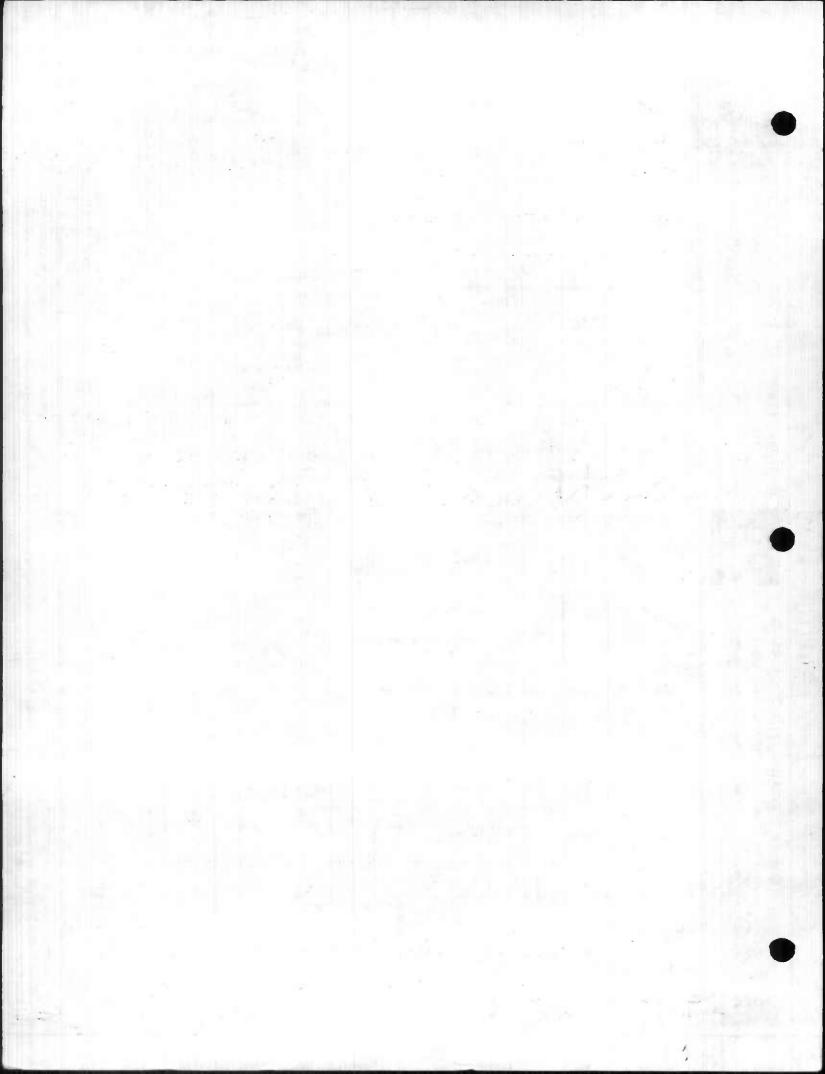
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State of Maryland / Department of Health and Mental Hygiene 99 25 171

	Certificate of Death		Reg. No.	40111				
hysician	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	nth Dey Year					
/Medical	SYDNEY H. SHOWALTER	JULY	23, 199	99 8:00 PM				
Examiner	4a Fecility Name (If not institution, give street and number) 4b. City, Town, or	Location of Death	4c. County of De	eath				
	CIRCLE MANOR NURSING HOME KENSING	TON	MONTG	OMERY				
ineral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr. Months Days Hours Mir		Yearl 9.B	lirthplace (State or Foreign Country)				
ector	547-38-6793 1 M 2 F 68 Yrs. Months Days Hours Mir	MARCH		CALIFORNIA				
2	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
notified at rector				1⊠ Yes 2□ No				
a to	MD. MONTGOMERY SILVER SPRING	1						
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?					
100	9500 BILIMORE DR. 20901		U.S.A					
Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - An Bleck, Wh	nerican Indian, hite, etc.				
	1 Never Married 2 Married 1 Yes 2 No No No Specify:		Specify:					
ò	3 ☐ Widowed 4 ☑ Divorced Year or Dates:		opecity.	WHITE				
202	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	orkina	16b. Kind of Busines	ss/Industry				
Completed	Elementary/Secondary (0-12) College (1-4or 5+)							
Š	2 OFFICE MANAGER		DIRECT MAIL					
80	17. Fether's Name (First, Middle, Last) 18. Mother's Na	ame (First, Middle,	, Maiden Sumame)					
101	BYRON QUAYLE	HELEN	WILK	TNS				
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route Numbe	r, City or Town, State	a, Zip Code)				
	KATHERINE A. SHOWALTER-MOORE/DAUGHTER 5210 GRETCHEN	ST KENS	SINGTON, M	m 20805				
	20s. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City					
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY	7/28/99	RIVERDALE	MD				
		وللالا وا						
	21. Signature of Funeral Service Licensee 22. Name end Address of Facility			20906				
	MOOO91 CHAMBERS FUNERAL	HOMES, P.	A., SILVER					
n al er	shock, or heart feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of):			Onset and Death				
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b							
by Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did t	obacco use contribu	Ite to the cause of death?				
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Completed			en autopsy med?	b. Were autopsy findings available prior to completion of cause of death?				
E		101	res 2 No	1 ☐ Yes 2 ☐ No				
Be C	25. Was case referred to medical 26. Place of Dr.	eath (Check only o						
0	examiner?		lence 6 Other (S)	neciful				
0	27. Manner of Death 28. Date of Injury 1 Nahural 5 Panding (Month, Day Year) Injury Work?	1	now injury occurred	респу				
ļ	M 1 Ves 2 No							
Certification:	3 Suicide 6 Could not be	28f. Location (5	Street and Number or	Rural Route Number.				
	4 Homicide determined determined building, etc. (Specify)	City or Tow	m, Stete)					
	29a. Certifier 773 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.							
edical	29a. Certifier (Check only ane) 125 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place (Check only ane) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	curred et the time,	date and place, and d	ue to the cause(s)				
ŝ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth. Day. Year)				
Darmo, PAM MA D34032 7/27/99								
			11/1					
		E KENS	SINGTON, 1	MD 20895				
tate	31. Date filed (Month, Day, Year)							
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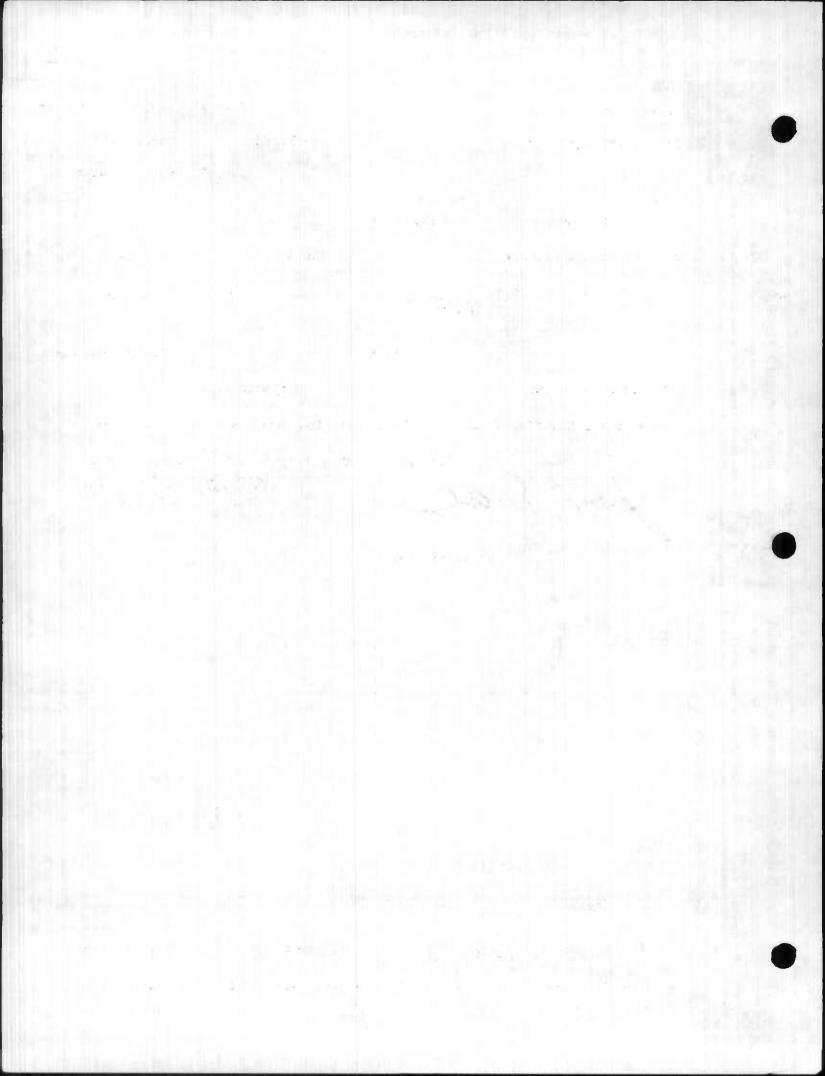
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** July 26, 1999 8:15 AM David Hall Stauffer /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 5113 Worthington Drive Bethesda If Under 1 Year | If Under 24 Hrs. 8. Dafe of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country)
 China 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys Hours 10XM 2□ F 148-16-5517 77 Yrs. 1921 Nov. 3, Director Usual Residence of Decedent parmit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notifyed at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 14 Yes 2 No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5113 Worthington Drive 20816 USA Funeral 12. Waa Decedent Ever in U,S. Amed Forces? 1 B Yes 2 D No If Yes, Give Feb 28 4 43 Yeer or Defe Nov 9 4 45 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian. Biack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Diplomatic US State Department Historian 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Milton T. Stauffer Marjorie Hall 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Doris Walker Stauffer/Wife 5113 Worthington Drive Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 27. 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State 1999 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alex., Virginia 22. Name and Address of Fedility DeVol Funeral Home 2222 Wisconsin Ave. 21. Signature of Prineral Service Licenses Washington, D.C. 20007 for the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final Pancreatic Cancer disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and the burial-transit that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 80 USB 0 signed by the a d be deteched f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 🕅 Unknown 1 | Yes 2 | No by The law requires 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Waa an autopsy periormed? s cartificata has t director, paga 2 s 1 Yes 2 No 1 Tyes 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1º 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA After this funeral 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 X Natural 1 Yes 2 No death. 2 Accident after deat Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) filled in by 4 | Homicide ò 24 hours Hospital 1 D. Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical complataly (Check only one) within 2 To the f To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) July 27, 1999 MD 25881 uan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3301 New Mexico Ave., N.W. #222 Wash., D.C. 20007 William S. Hughes, M.D. 31. Dete filed (Month, Day, Year) 32 Broth rar's Signature

State Registrar

JUL 28 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Month STE NIBORD 3:40 mm 24 NNA 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Hours Min. Sept. 3, 1938 If Under 1 Year 9. Birthplaca (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 10 M XX West Virginia 60 Yrs. 234-60-2856 Usual Rasidanca of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inaide City Limits Montgomery Silver Spring 1 ☐ Yas 2XXVo Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1131 University Blvd., West #1203 20902 United States 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1 Yas XX No Specify: Specify: XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Assistant Resident Manager Vista Management 12 17 Fethar's Nama /First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton Presgraves Myrtle Shingleton 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) same as #10 Joel N. Steinberg (son) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 7/27/1999 Silver Spring, Maryland 22. Name and Address of Fecility Donald V. Borgwardt Funeral Home, P.A. ra of Funarat Service Liner 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset and Death MALIGNAT Immediata Causa (Final GLIOMA hoodisaasa or condition resulting in daath) Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or Injury that Initiated evants rasulting in daeth) Last Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yas 2 No 26. Place of Death (Check only one) Hospital: 1 Impatiant Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding 1 SNetural

Examiner Examiner physician and the burial-transit that the death certificate be asseuted Box 68760. Physician/Medical 980 Po ed by the a P.O. Division of Vital Records, þ The law requires Completed page 2 certificate Be P this Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After I completely filled in by the funer

Physician

/Medical

Examiner

Director

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Berne 23a

Hied within 72 hours after. Hygiene, "netural", or its

permit. Pages 1 and 2 should be file.
Department of Health and Mertal Hyp important: if Ihan 27 is mented other any Injury or other traument other pages.

Physician

/Medical

Baltimore, Maryland 21215-0020

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> 25. Was casa referred to medical axaminar? 1 Yas 2 No

27. Mennar of Death

invastigation 6 Could not be

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

1 ☐ Yas 2 ☐ No

mination and/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s)

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28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in an examination daeth.

Medical Examiner: On the basis of exerged manner atated. one) 29b. Signatura and title of certifiar

31. Data filed (Month, Day, Year)

2 Accident

3 Sulcide

29a. Certifier

4 Homicida

(Check only

29c. License number 172967

29d. Data signed (Month, Day, Year)

1999

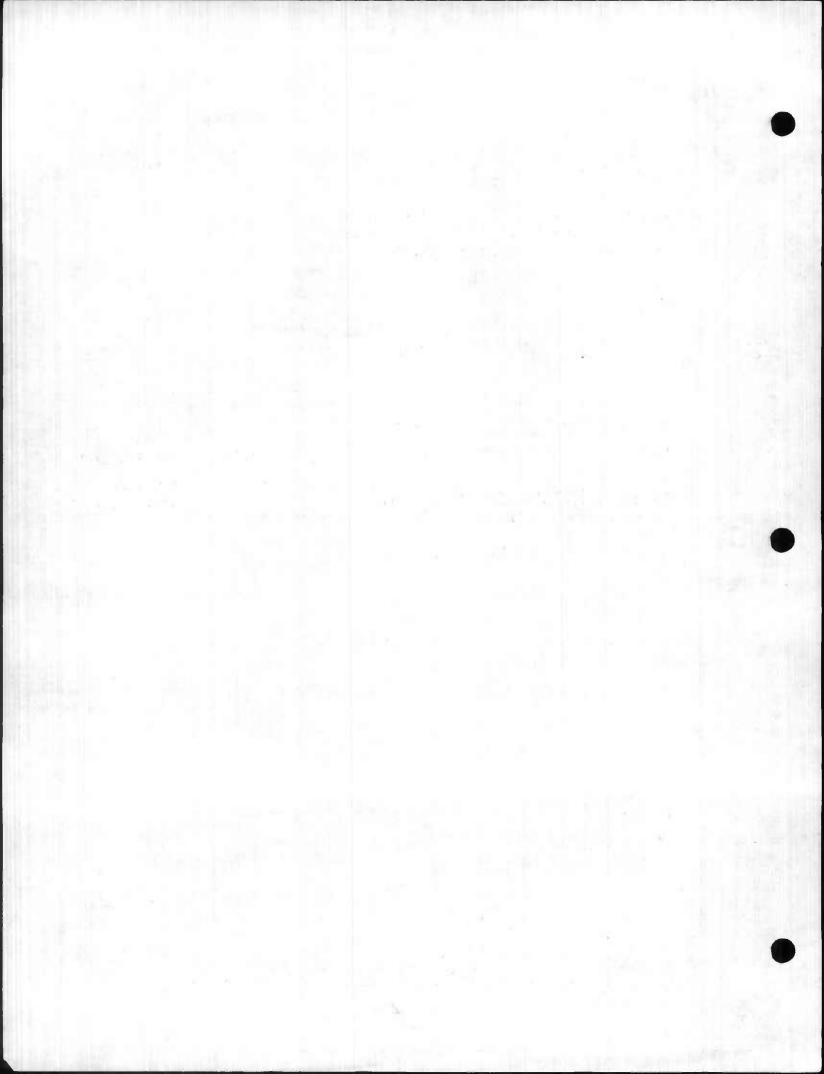
30. Nema and address of person who complated causa of death (Item 23e) (Type, Print) mosion Censor Tr

9707 RALPH BALLA

> 32. Ragistrar's Signatura 1999

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month George Hugh Cameron Stobie 1999 July 23 12:50 AM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda | If Under 24 Hrs. Suburban Hospital Montgomery 5. Social Security Number If Under 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) 6. Sex Birthplace (Stata or Foraign Country) Hours Days Min. 12 M 2□ F Months 469-48-4739 74 August 10,1924 Canada Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7007 Tilden Lane 20852 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, etc. 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2K No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry College (1-4or 5+) Elementary/Secondary (0-12) Surgeon Medical 17. Fether's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) George H. Stobie Helen M. Simpkins 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 20904 19a. Informent's Name/Relationship (Type, Print) George David Gordon Stobie (son) 13410 Fairland Park Drive Silver Spring, Maryland 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 II Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 7/24/99 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funarel Service Licenses 22. Nama and Address of Facility Francis J. Collins Funeral Home, Inc. pale 500 University Blvd., W., Silver Spring, MD 20901 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Immediata Cause (Finel pulmonary emboli week diseasa or condition rasulting in death) Dua to (or es a consequence of) month metastatic cance Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 ☐ Yas 2 ☐ No

Examiner physician and the burial-transit 7/23/99 12:50am Box 68760. Records, P.O. signed by d be detact should should page 2 s George certificate death. Stobie Director

Examiner edical Physician/M þ Completed 80 Certification:

Physician

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Physician /Medical

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72 hours after

Baltimore, Maryland 21215-0020

2 ☐ Accident 3 ☐ Suicide

25. Wes casa referred to medical axaminer? 1 Yas 2 No 27. Menner of Death 1 Natural

5 Pending investigation 6 Could not be detarmined

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

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28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier

4 Homicide

(Check only one)

29e. Certifier

edical

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State

Registrar

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29c. License number 043083 29d. Date signed (Month. Dav. Year) July 23

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD # 300

medical Center Drive

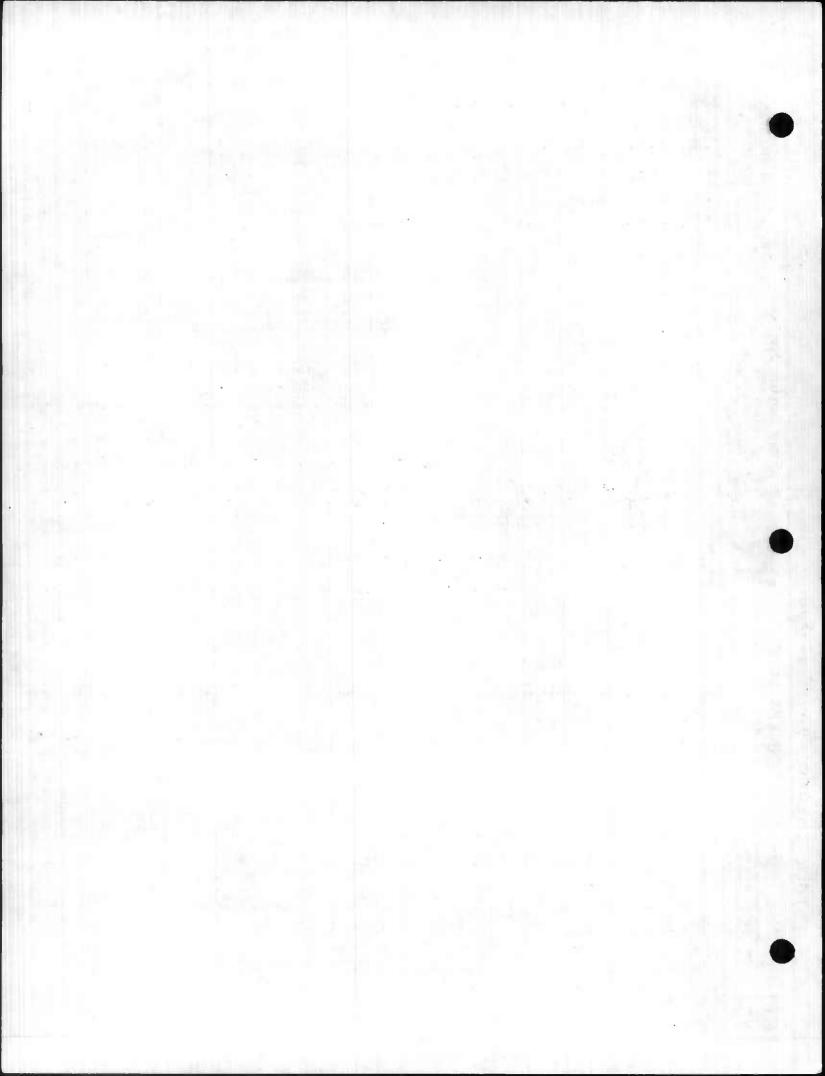
31. Data filed (Month, Day, Year)
JUL 2 6 1999

32. Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey 7:45 am JULY 26 1999 C . WILLIAM 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death ELLINGTON DRIVE ANNAPOLIS ANNE ARUNDEL 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Months Deys Hours Min 1 M 2 F 74 Yrs. APRIL 24 1925 MARYLAND 219-30-1497 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County MARYLAND ANNE ARUNDEL ANNAPOLIS 1 XYes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11 ELLINGTON DRIVE 21403 US 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Status 1 X Yes 2 □ No If Yes, Give Yeer or Detes: 1945-46 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry AZAR MOVING & Elementary/Secondary (0-12) College (1-4or 5+) 6th 0 PACKER STORAGE CO. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) WILLIAM STANSBURY LOLA IRELAND 19e. Intorment's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LINDA STANSBURY (WIFE) 11 ELLINGTON DR. ANNAPOLIS, MD. 21403 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 7/30/99 CROWNSVILLE, MARYLAND VETERAN CEME. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. Lavr Immediete Ceuse (Finel diseese or condition resulting in deeth) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events ne-of) Due to (or as a consequence ot): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown 24e. Wes an eutopsy performed? 24b. Were autopsy tindings evelteble prior to hoged Reflux Disease completion of ceuse of death? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of 28d. Describe how injury occurred

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Physician

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Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best ot my knowledge, death occurred et the time, date end plece, and due to the cause(s) end menner es stated. 29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29c. License number

trehesh

29d. Date signed (Month, Dey, Year) 20051325

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

4700-Ritchie Awy Severe PK, Md 21146 SAM ETHI ANGHA 31. Dete tiled [Month, Qay, Year)

Registrar

29b. Signeture end title of certifier

32. Registrer's Signeture

202 3 0 1939 James L. James

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death Month 4b. City, Town, or Location of Dea Medical Center Inne Arunde Annapolis If Under 24 Hrs Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Days 1 M 20XF Months Hours 15, 213-50-4639 1947 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 XNo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1583 Native Dancer Court 21401 United States 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 🖔 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Loan Officer Banking 17. Father's Nama (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Surname) F. Elmer Gelhaus Agnes Gustufson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chad E. Thomas (son) 1583 Native Dancer Ct. Annapolis, MD 21401 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Bluff Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7/29/99 Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licentes 147 Duke of Gloucester St. Annapolis, MD 21401 Derio M-I on 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death) morbid 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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Maryland 21215-0020

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Division of Vital Records.

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2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian (Check only one)

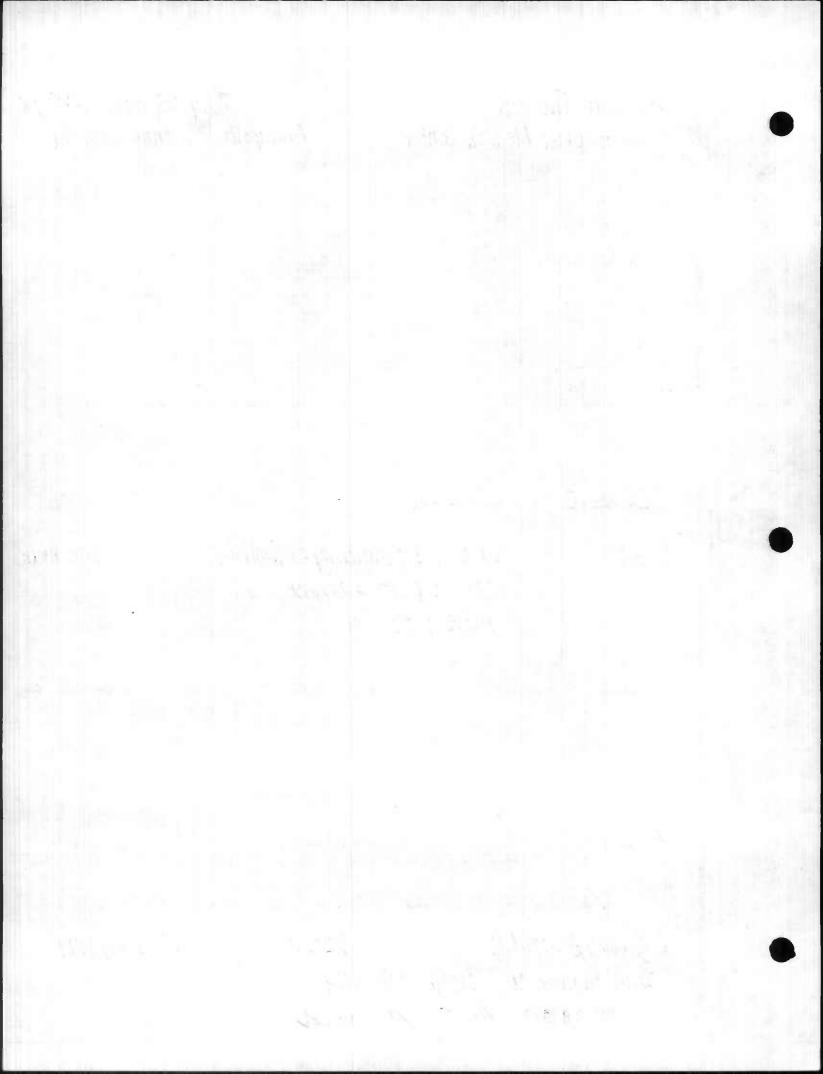
29b. Signature and title of certifier

29c. License number 28640 29d. Date signed (Month, Day, Year)

Jeffrey Briggs, M.D.

31. Date tiled (Month, Day, Year) JUL 2 8 1999 Hon

usa of death (Item 23a) (Type



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q 251

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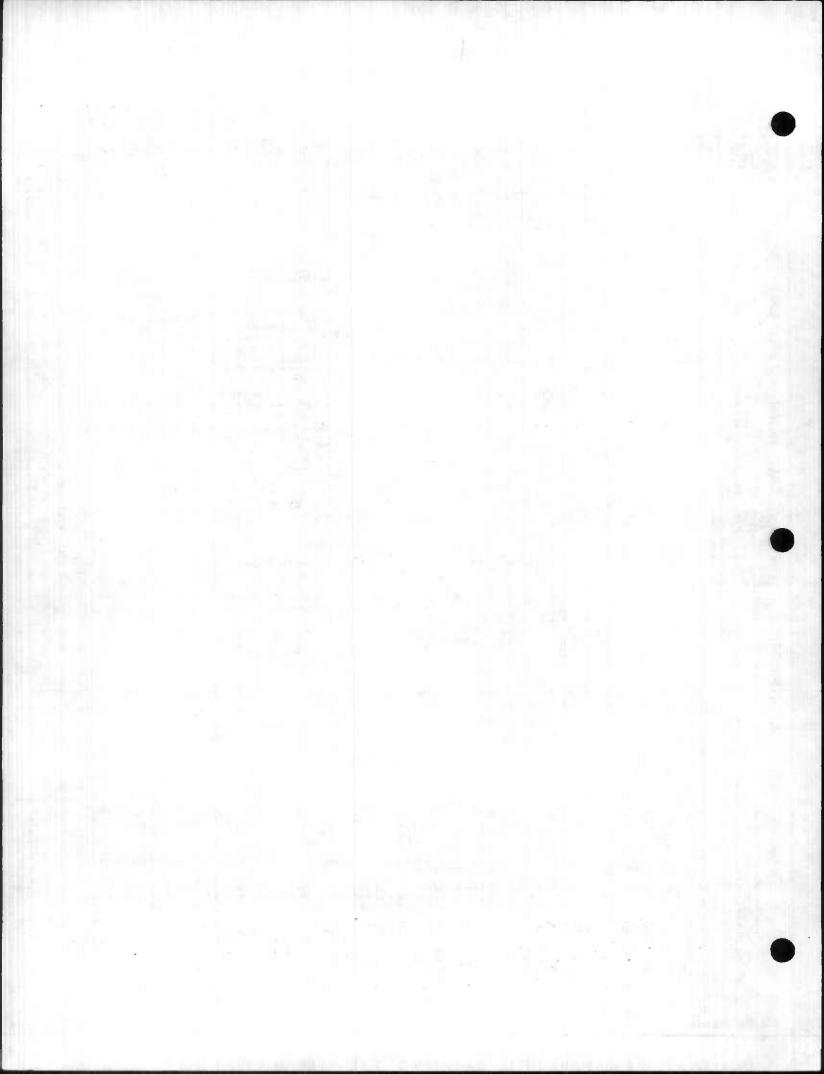
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State of Maryland / Department of Health and Mental Hygiene 9 25 1 78

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a 3	5 50							1,000	es 2 No	3 10	oubly 4 Onknown		
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Ö	the law require page 2 should b Completed b							perfor	med?	00	vailable prior to empletion of cause		
36	has pe 2								America	of	death?		
100	and S							1 U Y	as 2 No	1[☐ Yes 2☐ No		
Vital	Sertification of the sector	25. Was casa rafarred to medical examiner?	Hospital:			104		th (Check only or	ne)				
0	To To	1 Yes 2 No	Hospital: 1 Inpatient		patient 3 DOA		4 LI Nuising H	oma 5 Flesid			(y)		
u i	fler fler fler fler fler fler fler fler	27. Manner of Death 1 Sequence 5 ☐ Pending	28a. Data of tnjury (Month, Day Y	'ear) 28b. Ti		kc. tnjun Worl		28d. Describe h	ow injury occur	red			
Division	or: A	2 Accident investigation			M	10	Yes 2 □ No						
$\tilde{\mathbf{z}}$	rect by	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, fan 'Specify)	m, street, factory,	office		281. Location (S City or Tow		per or Rura	al Route Number,		
0	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. Medical Certification: To Be Comp												
1	hour hour hour hour hour hour hour hour	29a. Certifier 1 Certifying Physics (Check only 2 Medicat Example)	ysician: To the best of n	ny knowledge,	death occurred at	t tha tim	ne, data and place	, and due to the d	ause(s) and m	anner as s	stated.		
3	n 24 hou he Fune pietely fii edical	ane) 2 Medicat Exam	niner: On the besis of ex and manner state		or investigation, is	my o	pirilion, death occu	ried at the time, o	are and place,	and due to	O ura Cause(s)		
	Within To the	29b. Signature and title of cardiller 29d. Date signed (Month, Day, Year)											
	10	M2/1-	10			0	2/671		Wh 7	13	1959		
	f o	30. Name and address of person who	completed cause of deal	th (Item 23a) (1	Type, Print)					1			
		(2/1/2)	V RACC	10	200	9)	32hE	DICK	(95)	-1	7		
	State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	, ,	17	7		0	1	7/1		
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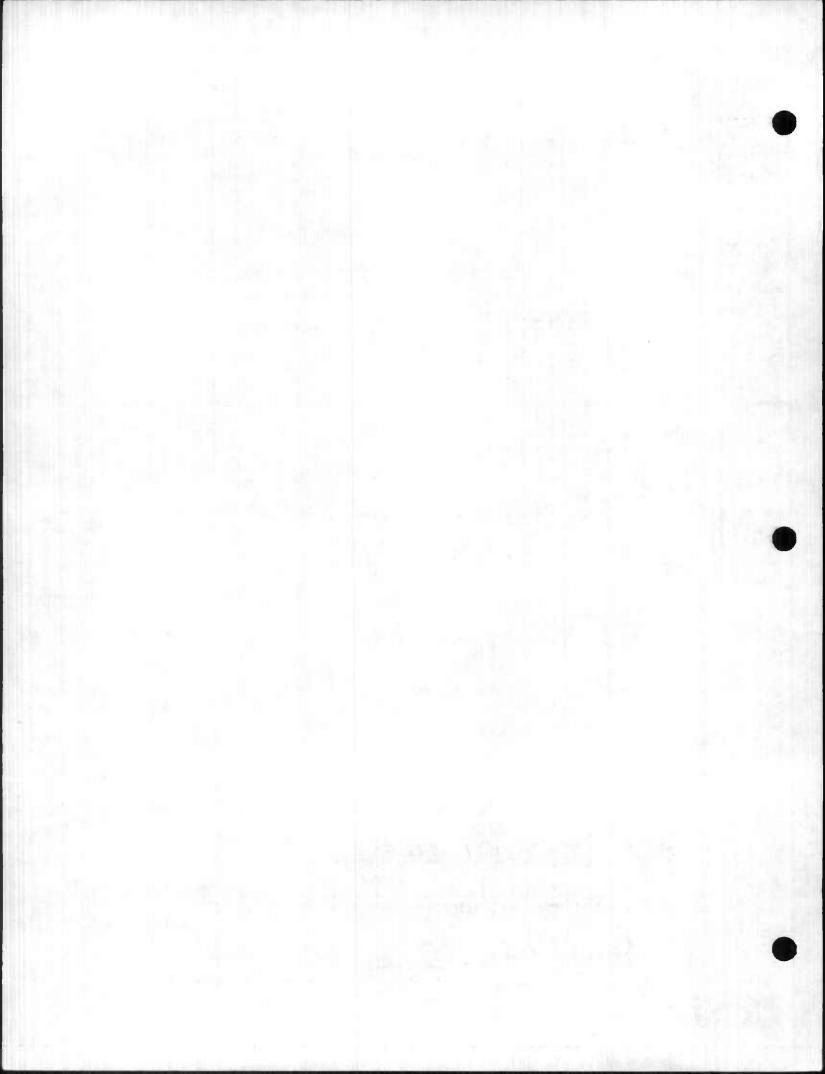


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State of Maryland / Department of Health and Mental Hygiene 9 9 25 1 7 9

				Cei	rtificate o	r Death		1	Reg. No.					
Dhominian	1. Decedent's Neme (First, Middle,	Last)					2	. Date of De Month		Year				
Physician Medical	Addeline Rose	Van Cam	p					July	21 :	1999	01:25 PM.			
Examiner	4e Facility Neme (If not institution,	rive street and nur	mber)			4b. City, To	own, or Loca	tion of Death	4c. County	of Death				
	Prince Geor	ge's Hos	pital Cen	ter		Ch	everly	Y	Princ	ce Geoi	rge's			
Funeral	5. Social Security Number 6		7. Age (In yrs. last	birthday)	If Under 1 Yes		Min. 8	. Date of Birt (Month, Da	h Yearl	9. Birthplace	e (State or Foreign			
Director	218-38-6818	1□M 2\ F	89	Yrs.	months buj	110013			3, 1910					
2	Usual Residence of Decedent		T 27 2											
death with the Manyland rms 23e or 28e-f show r must be notified at meral Director	10a. State 10b. County		10c. City, To	or Lo	ocation									
No Maria	Maryland Prince	George's			College	Park					1 Yes 2 No			
vith the Ma or 28a-fa be notified	10e. Street and Number				10f. Zip Code			- 174	10g. Citizen of What Country?					
23a 23a		ne				20740			USA					
after death with the Manylar or frems 23a or 28a-f show trainer must be notified at V Funeral Director	11. Merital Stetus	12. Wes Dece Armed Fo	edent Ever in U,S.	13.	Was Decedent of Yes, specify Co	f Hispanic Ori	rigin? (Speci	fy Yes or No-						
of 2 should be filed within 72 hours after the not Mental Hygiene. 77 is marked other than "natural", or it traumatic event, the Medical Eventin. To Be Completed by Ft.			2⊠No		1□ Yes 2☑N									
5 4 0	3 ☑ Widowed 4 □ Divorced	Year or D	ates:			о ороспу.			Specify	3. Time of Deeth Prince George's 9. Birthplace (State or Fore Country) Michigan 10d. Ineide City Limit 1 Yes 2 1 1 1 Yes 2 1 1 1 Yes 2 1 1 1 1 1 Yes 2 1 1 1 1 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
ed within 72 hours ygiene. wr than "natural", it, the Medical Ex-	15. Decedent's (Specify only highest)	Education	16	Sa. Dece	dent's Usual Occ	upation e durina mos	st of working		16b. Kind of Bu	siness/Indust	iry			
d within giene.	Elementary/Secondery (0-12)	College (1	I-4or 5+)	life.	DO NOT use reti	red)								
Hygier the		3	R	egis	stered N	1								
tal Hyginal d other avent, to	17. Father's Name (First, Middle, La	st)				18. Moth	er's Name (First, Middle,	Maiden Sumer	10)				
The state of	Ray Darrow Ros							May Ru						
end la ma	19e. Informant's Name/Relationship	(Type, Print)	11	9b. Mailie	ng Address (Stre	et and Numb	er or Rural I	Route Numbe	er, City or Town,	State, Zip Co	de)			
C 7 67 F	Kathleen R. Ewel	1(dau				st Hig	hway	Chevy	Chase, N	Marylar	nd 20815			
pemit. Pages 1 an Department of Heal Important: If tem 2: any Injury or other once.	20a. Method of Disposition	ПР	0000	of Dispo	osition (Name of metory or other p	lece)		Date	20c. Location -	City or Town,	Steta			
Pages nent of I mt: If he rry or o	1 ☐ Burial 2 ☐ Cremetion 3 4 ☑ Donetion 5 ☐ Other (Spe			Anai	tomy Poo	m d	¦ u	nk	altimor	o Mary	land			
pemit. Pa Departmen Important: any Injury once.	21. Signature of Funerel Service Lin	21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc.												
Depa impo any i	Jign. 1	1/2	2											
	220 Part Enter the deages or or	maliantians that a	nured the death. D											
	23a. Pert1. Enter the disease, or co shock, or heart feiture. List on	ly one cause on e	ech line.	O HOL OIL	tor the mode of c	yang, such as	Cardiac or i	espiratory er	1031,	Ini	ervel Between			
Physician /Medical	Immediate Cause (Fine)													
Examiner	disease or condition													
		Due to (or as a consequence of):												
is of		b								i				
and Hran	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying		Due to (or as	a consec	quence of):									
ding physicien and se as the burial-transit	cause. Enter Underlying Cause (Disease or Injury	C.												
the the	thet initiated events resulting in death) Last Due to (or as a consequence of):													
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igned by the attent be deteched for un by Physician	Pert If. Other eignificant conditions	contributing to de	eath but not resulting	in the u	nderlying cause	given in Part	f.	23b. Dld 1	tobacco uee co	ntribute to the	e cause of death?			
ed by the detection								10	Yes 25 No	3 Probab	ly 4 Unknown			
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page 2 should be										availal	ble prior to			
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certificate rector, pa	25. Wes case referred to medical					26 Plan	a of Dooth (1	22.10			
director.	examiner?	Hospitel:	nnation: oVIEn	Outration	nt 3 DOA	Other				er (Snarihi)				
£ 6	- 1	1		. Time of	II JU DON	4LI N	28	d. Describe l	now injury occur	red				
Afte Afte	1 Natural 5 Pending		of Injury th, Day Year)	Injury		juryat /ork? □Yes 2月								
deal ctor.	3 Suicide 6 Could not	be 200 Place	of Injury - At home,	ferm at	1			Location (Street and Numb	er or Rural Re	oute Number.			
as after death. al Director: After the did in by the funera Certification:	4 Homicide determine	buildir	ng, etc. (Specify)		treet		40	24 or Jon	en Statel #3	100				
The state of		Colleg	efack,	16.60	100									
ne Hospi in 24 hou he Funer pletely fill edical	(Check only 2 Medicat Ex													
To the Hospital of Attanding Pri within 24 hours after death. Completely filled in by the funeral Medical Certification:										d Month Day	Vesr)			
	29b. Signeture and title of certifier	101.				C.M.E.				.10 110 000	11 377			
0	Vennis Chicken							23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24a. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 25f No Seath (Check only one) 26f Describe how injury occurred Motor Well, Check Collision 28f Location (Street and Number of Rural Route Number, for one State) 28f Location (Street and Number of Rural Route Number, for one State)						
	30. Neme and address of person wh	completed caus							7 - 7 01	20:				
	Vennis J. (hute no	111	Peni	n Street	, Balt	umore	, Mary	mand 21	201				
State	31. Date filed (Month, Dey, Year)	32. F)	egistrar's Signature											

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 420A ANNA Elizabeth WHITLOCK 24 ULI 4e Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 11 CLAGE PARKVILL 8800 HALTHER BLYD

Days

10f. Zip Code

21234

1 ☐ Yes X☐ No

Homemaker

20b. Plece of Disposition (Name of cemetery, crametory or other plece)

a

Due to (or as a consequence of)

Due to (or es e consequence of):

Due to (or es e consequence of):

Seaville Cemetery

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

If Under 24 Hrs.

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

Trene

22. Name and Address of Fecility
McComas Funeral Home, P.A.

8. Dete of Birth (Month, Day, Year)

18. Mothar's Nema (First, Middle, Maiden Sumame)

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)

1317 Cokesbury Road, Abingdon, MD 21009

1304 Henderson Ct., Bel Air, Maryland 21014

(umn)

June 18,1912 Pennsylvania

10g. Citizen of What Country?

Specify:

Own Home

16b. Kind of Business/Industry

Talbot

20c. Location - City or Town, Stete

7-26-99 Seaville, New Jersey

14. Race - American Indian, Black, White, etc.

White

USA

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 20No

EAR

7. Age (In yrs. last birthday) If Under 1 Year Months Days

10c. City. Town or Location

Parkville

Physician /Medical Examiner 5. Social Security Number **Funeral** Director 207-36-1705 Usual Residence of Decedent the Menyland 10a. Stete permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frems 23s or 28a-f show any injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event. Directo Maryland 10e. Street and Number 8810 Walther Boulevard Funeral 1 Never Merried 2 Married Maryland 21215-0020 à 3€ Widowed 4 Divorced Completed Elementery/Secondery (0-12) 17 Father's Name (First Middle Last) Be Charles 19a. Informent's Neme/Reletionship (Type, Print) Allen A. Whitlock, son Baltimore, 20a. Method of Disposition Burlel 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a. Pert1. Enter the disease, or complication. that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heer teilure. List only one cay on each line. **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in daeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

sician and bunial-transit attending physician Physician/Medical the USB 1 p Completed 2 this Certification:

Box 68760.

P.O.

Records,

Division of Vital To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Sul

State

26. Place of Death (Check only one) Other: Nursing Home 5 Plesidence 6 Other (Specify) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA ZIA No 1 Yes 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the Cest of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and menner as stated.

[2 Medical Examiner: On the Cest of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and my more stated. 29a. Certifian (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and titla of certified 29c. License number redy who completed cause of death (Itam 23a) (Type, Print) 30. Name and address of person M. J. 8800 WALTHER 1RF1S PARKVILLE, MS. REDRIC 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture Registrar **ORIGINAL**

25. Was case referred to medical

6. Sex

10b. County

Baltimore

15. Decedent's Education (Specify only highest grade completed)

Meyers

12

1□M 2X)F

12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ②☐ No If Yes, Give Yeer or Detes:

College (1-4or 5+)

Waters

Part II. Other significant conditions contributing to death but right resulting in the underlying causa given in Part I.

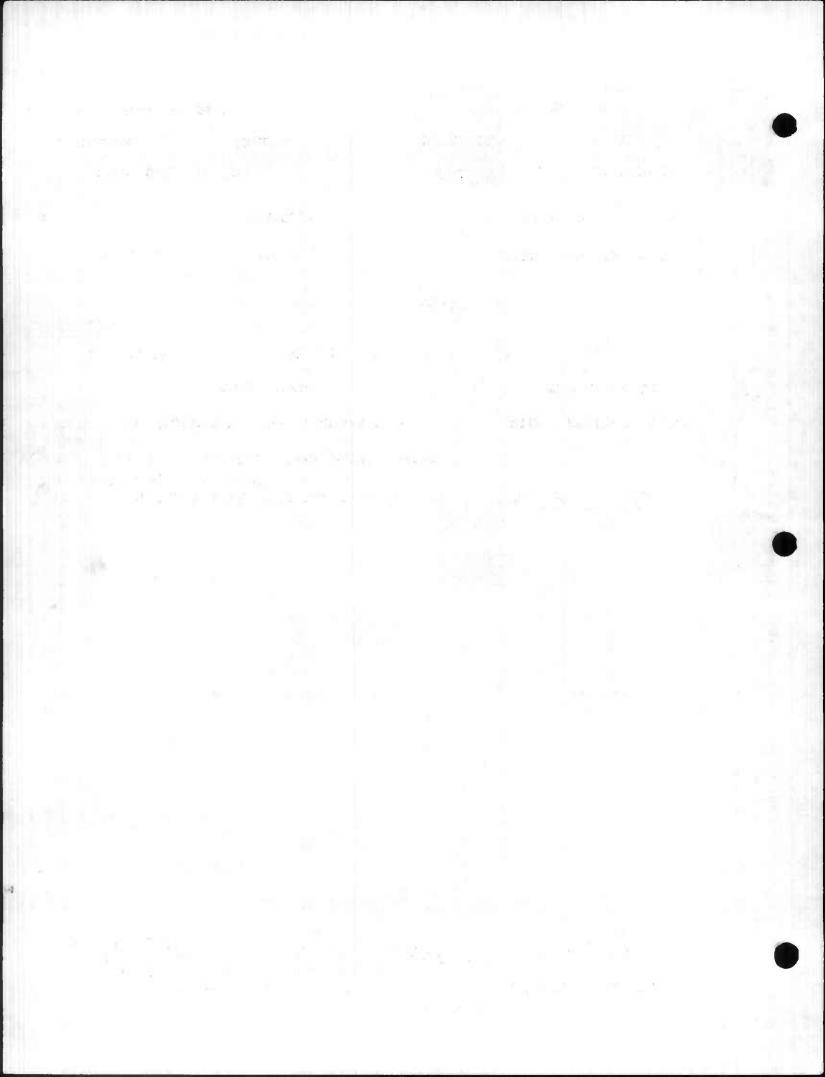
monary 1) sease

23b. Did lobecco use contribute to the cause of death? 10 Tes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

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			Decedent's Neme (First, Middle, Le	State of N					Death			Reg. No.	9 2	5181
	Physic /Medi		MAX WE	NGER							Dete of De Month JULY	22 19		3. Time of Death 6:45 AM
	Examir Funeral Director	ner	4e. Fecility Neme (If not institution, given NATIONAL NAVA 5. Sociel Security Number 6. Security Number 297-07-0702	L MEDICAI	CENT	TER lest birthdey) Yrs.	If Unde	or 1 Year	_	THESD	A Dete of Birt		MONTGO	OMERY ce (State or Foreig
		or	Usuel Residence of Decedent 10a. Stete 10b. County VA ARLING	TON		ty, Town or Lo	cation		ARLING		0. 19	, 1920	T.	d. Inside City Limit
	ith with the Maryla 23a or 28a-f ahor ust be notified at	Funeral Director	10e. Street and Number 3424 N. VENICE				10f. Zi	p Code	222			10g. Citizen of 1	What Country	y?
020		þ	11. Meritei Stetus 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 12 Yes 2 E If Yes, Give Yeer or Detes	No WW	11	Ves Dece Yes, spe		Hispanic Origi en, Mexican, Specify:	in? (Specify Puerto Rice	Yes or No- an, etc.)	14. Red Biel Specify	ce - American ck, White, et y: WHI	c.
21215-0020	within 72 hours iene. than "natural", the woulds!	Completed	15. Decedent's E (Specify only highest gra Elementery/Secondery (0-12)	ducation ade completed) Coilege (1-40	r 5+)		kind of w OO NOT u	ork done ise retire	pation during most of d)	of working		16b. Kind of B	usiness/Indu	
Maryland	would be filed Mental Hygi arked other atic event, I	To Be Co	17. Fether's Name (First, Middle, Last CHARLES WENGER	.					18. Mother PEARL	FAI	R	Meiden Suman	ne)	
more, mar	permit. Pages 1 and 2 sho Department of Heelth and Important: If flem 27 is me any Injury or other traum ance.		19a. Informant's Neme/Raiationship (NANCY S. WENGER — 20e. Method of Disposition 1⊠ Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specification of the content of t	WIFE	0		N. V	ENIC me of other pla	E STRE	ET A	ARLING	20c. Location	VA City or Tow	22207
Baltimore,	permit. F Departme importan any injur		21. Signeture of Funerel Service Licer	. Horn	bat	22 5	Neme e	nd Addre	VE. N.	JOSE!	PH GAN	WLER'S S	SONS	20016
	Physician /Medicai Examiner	36	23a. Pert1. Enter the disease, or com shock, or heert feilure. List only Immediate Cause (Final disease or condition resulting in deeth)		VENT	RICULAR	MAS	S	ng, such es ca	ardiec or re	spiretory er	rest,	ic	Approximete nterval Between Onset and Death
007 007 00	death certificate be executed e attending physician and of for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in deeth) Lest	b		or es a consequ								
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= 1	Physicien: The I this certificate he ral director, page	To Be Co	25. Was case referred to madical examiner? 1 □ Yes ②□ No	Hospitel: 1 XInpa	tient 2	ER/Outpatien	3 D	OA Ott	nor:	of Death (Co		3111 - 3 - 7 111		Yas 2□ No
	ttending death. stor: After y the fune	Certification:	27. Menner of Death 12 Neturei 5 Pending investigation 3 Suiclde 6 Could not be determined	28e. Place of I	njury - At h	28b. Tima of Injury	М		ryet rk? ∣Yes 2 □ No	o 28f.	Location (5	now injury occur		Route Number,
	spital or nous aft neral Di y filled in	building, etc. (Specify) 29e. Cartifier (Check only one) 1 Cartifying Physician: To the best of my knowledga, death occurred e 2 Madical Examiner: On the best of examinetion and/or investigation, and menner stated.						et the ti	City or To			ceuse(s) and me	enner as stat and due to the	led. ne cause(s)
	To the Ho within 24 i	Mec	29b. Signeture and title of certifier		_ /	20		RES	nse number 29d. Date signed (Month, Day, Year) 23 JUY 99			ıy, Year) 99		
	Sta	te	30. Nama and eddress of person who M.A.SIPE, LT, 31. Date filed (Month, Dey, Year)	MC, USN 32. Ragis	death (Iten		Print)		IONAL I			CAL CENT	TER .	

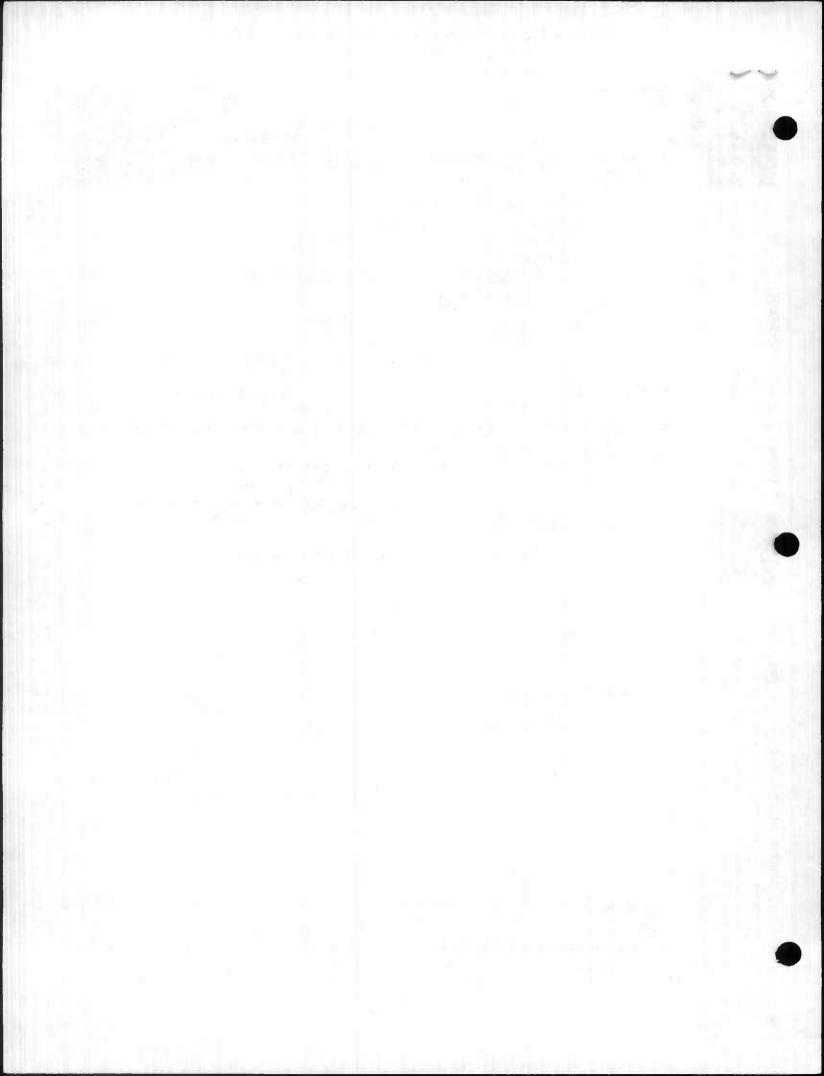


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State of Maryland / Department of Health and Mental Hygiene
per MD, JW, Montg. Co. Certificate of Death

Reg. No.

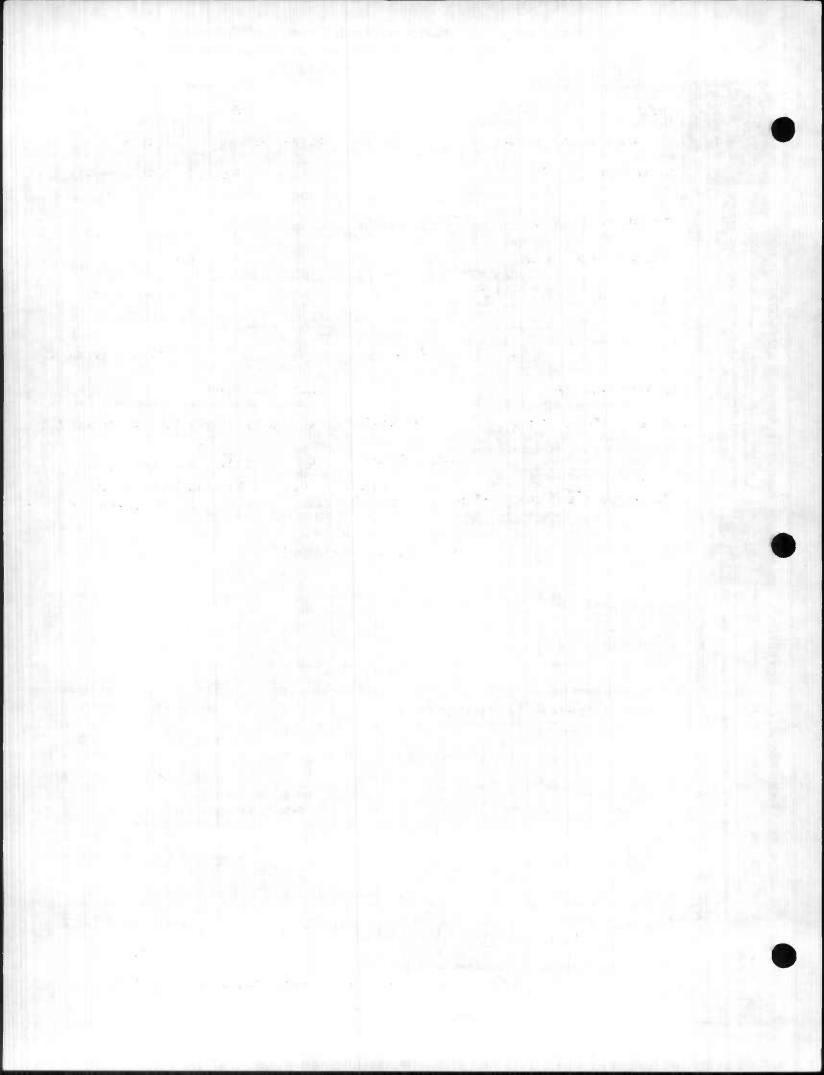
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	how		Usual Residence of Decedent 10a. State 10b. County	10c. C	city, Town or Loc	cation				100	f. Inside City Limits
	with the Merylan or 28a-f show	Director	Maryland Montgome	ry	Wheat		10		40- 011	17-1-0	1 ☐ Yes 2 ☐ No
	3a or		13324 Foxhall Dri	ve		10f. Zip Coo	906		10g. Citizen of V	vnat Country	,r
	er deetl	Funeral		12. Was Decedent Ever in Armed Forces?	U,S. 13. V		of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yas or No		e - American	
020	a 9 E	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give 196 Yaar or Datas: 10			No Specify:		Specify	7	
21215-0020	72 hours	eted	15. Decedent's Edu (Specify only highest gredi	cetion	18a. Deced	ent's Usuai Oc	coupation one during most of wo	odkina	16b. Kind of B	Whi:	
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Maryland	0 10 33 0	ToE	Frank R. West					inia Hus			
Mar	01 00 00 00		19a. Informant's Neme/Relationship (Ty				reet end Number or F				
ore,	es 1 and 2 should by of Health end Ment of Health end Ment filtern 27 is marked or other traumatic endings.		Aaron Matthew West 20a. Method of Disposition		Place of Dispos cemetery, crem	ition (Neme o	1	Wheaton,	Maryland 20c. Location -	City or Town	n, State
Baltimore,	Pege ment o ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)					7/26/99	Silver S	Spring	,Maryland
Ball	permit. Peges Department of Important: If Its any Injury or o		21. Signature of Funaral Service License	90	Fra Fra	Nama and Ad ancis J	drass of Facility Collins	Funeral	Home,	Inc.	
Г			23a. Part1. Enter the diseasa, or complishock, or heert failure. List only or	cations that ceused the day	500 ath. Do not ante	Unive	rsity Blvddylng, such as cerdia	d., W., Si ac or respiratory a	lver Sp:	A	D 20901 Approximate Interval Between
	Physician /Medical Examiner			ARTENIOSCUM		DioUazo					Onsat and Death
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,00	cete be executed physician end s the burief-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events	Due to	(or as a consequ	uence of):					
Box 68760,	5 00	in/Medical	that initiated events resulting in death) Last		or as a consequ	rence of):					
	that the death cer ed by the attendir deteched for use	sicia	Pert II. Other significant conditions con	tributing to death but not re	sulting In the un	derlying ceuse	given In Part I.	23b. Dld	tobacco use co	ntribute to ti	he cause of death?
P.O.	ires that the signed by Id be detect	by Physician/						汶	Yes 2□ No	3 Probe	bly 4 ☐ Unknown
Records,	w requires s been sign	Completed b						24a. Was perfo	an autopsy rmed?	avail	e sutopsy findings able prior to pletion of cause eth?
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State of Maryland / Department of Health and Mental Hygiene

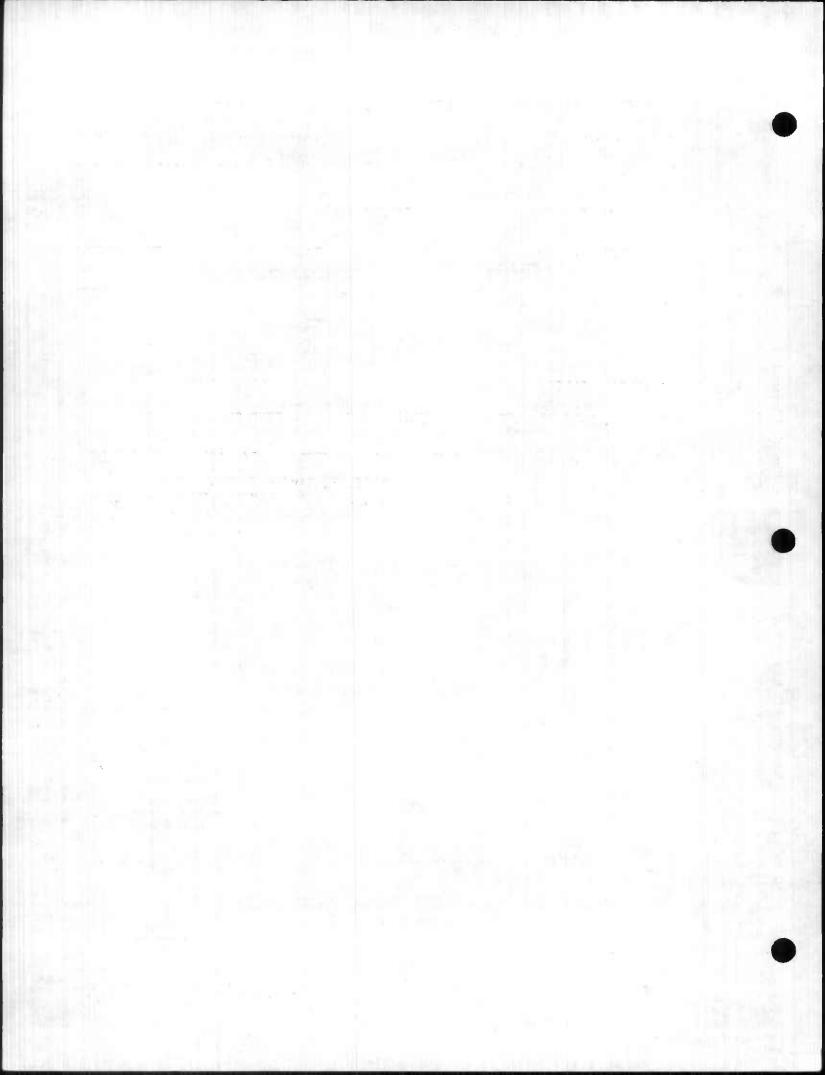
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State of Maryland / Department of Health and Mental Hygiene 9 9 25 | 8 4

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The state of the control of the co	27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5th Residence 6 Other (Specify) 27. Manner of Death 1 Montarial 2 Accident 3 Suicide 4 Hornicide 5 Pending investigation 3 Suicide 4 Hornicide 28e. Date of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Death 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier (Check only one) 29e. Signature and title of certifier 29e. License number 29d. Date signed (Month, Day, Year) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 30. Name and address of parson what completed cause of death (Item 23a) (Type, Print) 30. Name and address of parson what cause (Item 23a) (Type, Print) 30. Name and address of parson what ca	tor, p	25. Was case referred to medical			26. Place of Dea	th (Check only one)	
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how inju	27. Manner of Death Minatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1		Hospital:	1 Inpatient 2 ER/Ou	tpatient 3 DOA	Other: 4 Nursing He	ome 56Aesiden	ice 6 Other	(Specify)
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and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30c. License number	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	oly filled Cal Ca	(Check only 2 Medical Examiner: On	o the best of my knowledge	, death occurred at ti	he time, date and place, my opinion, death occur	and due to the cau	use(s) and mann	ner as stated. d due to the cause(s)
290. Date signed (Month, Day, Year) 290. License number 290. Date signed (Month, Day, Year) 301. License number 302. License number 303. JULY 23,1999	30. Name and address of person whe completed cause of death (Item 23a) (Type, Print)	0	ane) and	manner stated.					
1) (9007)	30. Name and address of person whe completed cause of death (Item 23a) (Type, Print)	E S	290, Signature and title of certifier		29C. LI	Cense number			
any for the state of the state	30. Name and address of person why completed cause of death (Item 23a) (Type, Print)	W (comp	1 1/1			11101/07		JULI LU	12000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		dwoo 5	> Employ	~ com		145781			



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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day 23, PEARL E. WINPISINGER JULY 1999 1:15 A.M. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 3509 TWIN BRANCHES COURT SILVER SPRING MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 X F Yrs. 72 JAN. 15, OHIO Usuel Residence of Deceden 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MONTGOMERY SILVER SPRING 10f. Zip Code 10g. Citizen of What Country? 3509 TWIN BRANCHES COURT 20906 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 0 HOUSEWIFE HOME 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) MILDRED RANDOLPH 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICKIE L. WINPISINGER - DAUGHTER 12329 NEEDLEPINE TERRACE, SILVER SPRING, MD 20904 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from Stete 5 Other (Specify) LINCOLN CREMATORY 7-24-99 BRENTWOOD, MARYLAND 21. Signature Funeral Service Chans 22. Name and Address of Fecility HINES-RINALDI FUNERAL HOME, INC. 11800 BEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 orus of 1 that the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rheart failure. List only one cause on each line. Approximata Interval Between Onset and Death METASTATIC NON-SMALL CELL LUNG CANCER 7 MONTHS Due to (or as e consequence of): Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1XXYes 2 No 3 Probably 4 Unknown SEIZURE DISORDER

Physician /Medical Examiner

> burial-tran and

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signed by the a

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certificate

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificiety filled in by the funeral director,

To the I

Completed by

Be

Certification: To

Medical

physician

The law requires that tha death certificata be axecuted

Box 68760,

P.0.

of Vital Records,

Division

Physician

/Medical

Examiner

Funeral

Director

28e-f show

8 23a

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natural

Hygiene.

. Pages 1 and 2 should be till mant of Health and Mental H tant: If them 27 is marked off flury or other traumatic even

Department of important: If any injury or

2

filed within 72 hours after

21215-0020

Baltimore, Maryland

must be notifie

Director

Funeral

by

Completed

5. Social Security Number

275-20-9483

MARYLAND

11. Marifal Status

10e. Street end Number

12

CLYDE FOSTER

4 Donetion

10a State

Examiner Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Couse (Disease or Injury that initiated events rasulting in death) Lest Physician/Medical

Immediate Cause (Final

disease or condition resulting in deeth)

Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC LUNG DISEASE

24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 20 No 1 ☐ Yes 2KINo

25. Was case referred to medical exeminer? 1 Yes XX No

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28h Time of 28c. Injury et Work?

26. Place of Death (Check only one) Other: 4□ Nursing Homa 5₺ Rasidence 6 □Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 ZNaturel 2 ☐ Accident 3 ☐ Suicide

4 Homicide

5 Pending investigetion 6 Could not be datermined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 | Yas 2 | No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 💢 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and dua to tha cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certified

29c. License number

29d. Data signed (Month, Day, Year)

D35996 JULY 23, 1999

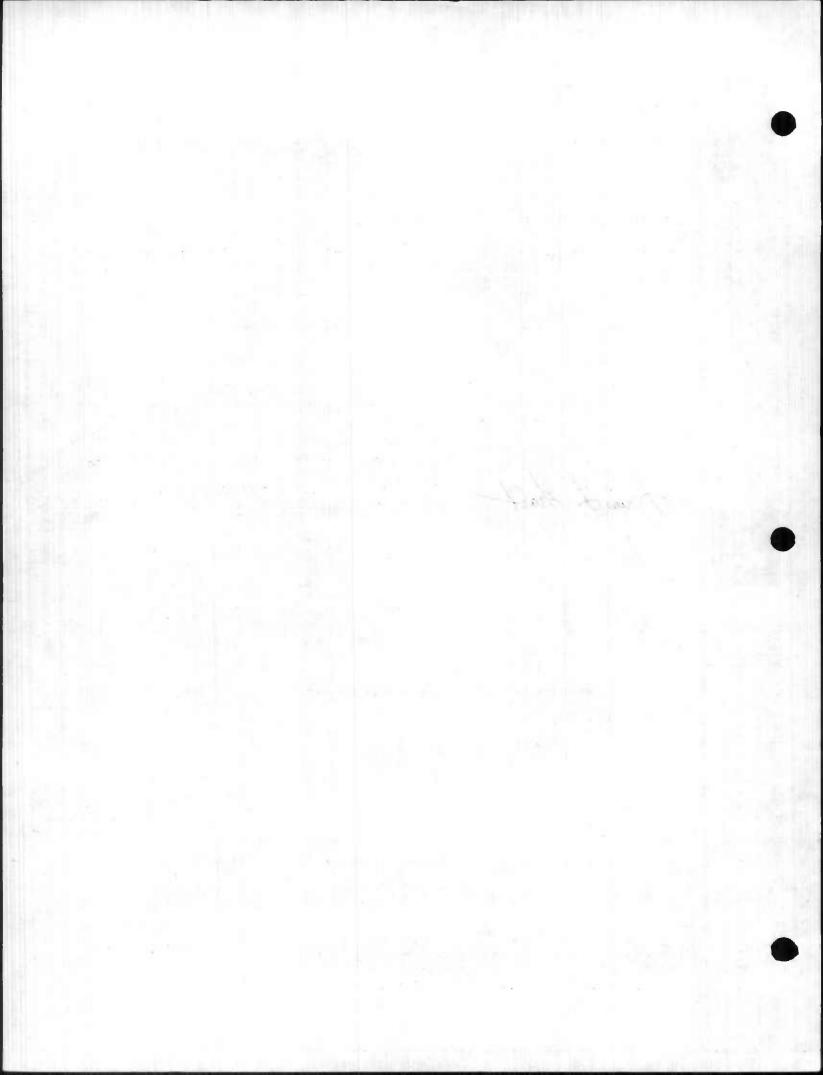
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

LINDA BURRELL, MD, 2101 MEDICAL PARK, #210, SILVER SPRING, MARYLAND 20902

State Registrar

completely

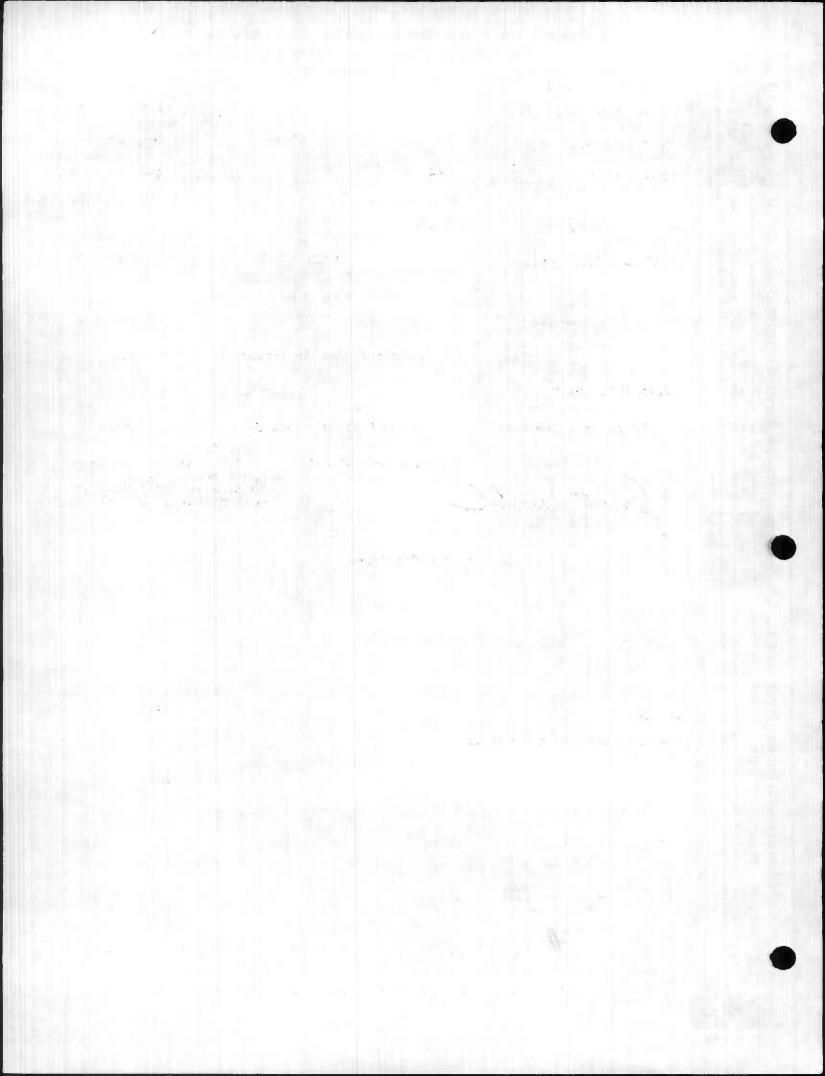
31. Dete filed (Month, Dey, Year)
JUL 2 6 1999 32. Registrar's Signeture sach



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sician	1. Decedent's N	eme (First, Midd	le, Last)		001	tificate of I	J Galii	2. Dete of Dee	Reg. No. eth		3. Time of Death
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	17400 L	afayette	Drive				Olney		Montge	omery	
ral	5. Social Securit		6. Sex 1 ☐ M 2 N F		. lest birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, De)	, Year)	9. Birthpl	lace (Stete or Foreign try)
tor	320-40-		10 M 2 <u>A</u> F		+4 Yrs.			June 30), 1955	I11:	inois
	Usual Residence	10b. County		10c. C	ity, Town or Lo	cation				10	Od. Inside City Limits
rector	MD	Montre	morri		11						1 ☐ Yes 2 No
Directo	10e. Street and	Montgo Number	mery		Olney	10f. Zip Code			10g. Citizen of V	Whet Coun	try?
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Funerai	11. Marital Statu			edent Ever in U	J,S. 13. V		ispanic Origin? (Span, Mexican, Puerto	ecity Yes or No-		e - America	
by Fu		lerried 2 Mar d 4 Divorced	rled 1 ☐ Yes	2 No		☐ Yes 2 X No	Specify:	ruoan, oto.,	Specify	,	ite
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	1 Go.	Ant.	Complications that conly one cause on e	6			Ga:	Vol Fune E. Deen ithersbu	irg, MD	Drive 2087	7
Medical Examiner	disease or cond resulting in deal Sequentially list if any, leading to cause. Enter Ur Cause (Disease that thitlated everesulting in deet	conditions, o immediate inderlying o or injury ents	b	Due to (or as a consequence or as a consequence or as a consequence or as a consequence of the co	uence of):				1	
Physician/M	Part II. Other sig	gnificant condition	ons contributing to de	eath but not re	sulting In the ur	nderlying ceuse giv	en in Part I.	23b. Dld t	obacco uae co	ntributs to	the cause of death?
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State of the last	Tnannua	priate A	nti Diure	tic				24e. Wes	an eutopsy med?	eva	ere autopsy findings ailable prior to mpletion of cause death?
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To Be	25. Wes case re	oferred to medica No eath 5 Pendir Investi 6 Could	Hospital: 1 28e. Date (Mon gation not be pined 28e. Place	of Injury th, Dey Year)	28b. Time of thijury	28c. Injur	er: 4 Nursing Ho	h (Check only o	ne) lence 8 Oth now thjury occur.	ner (Specify	y) il Route Number,
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 9 9 25 |

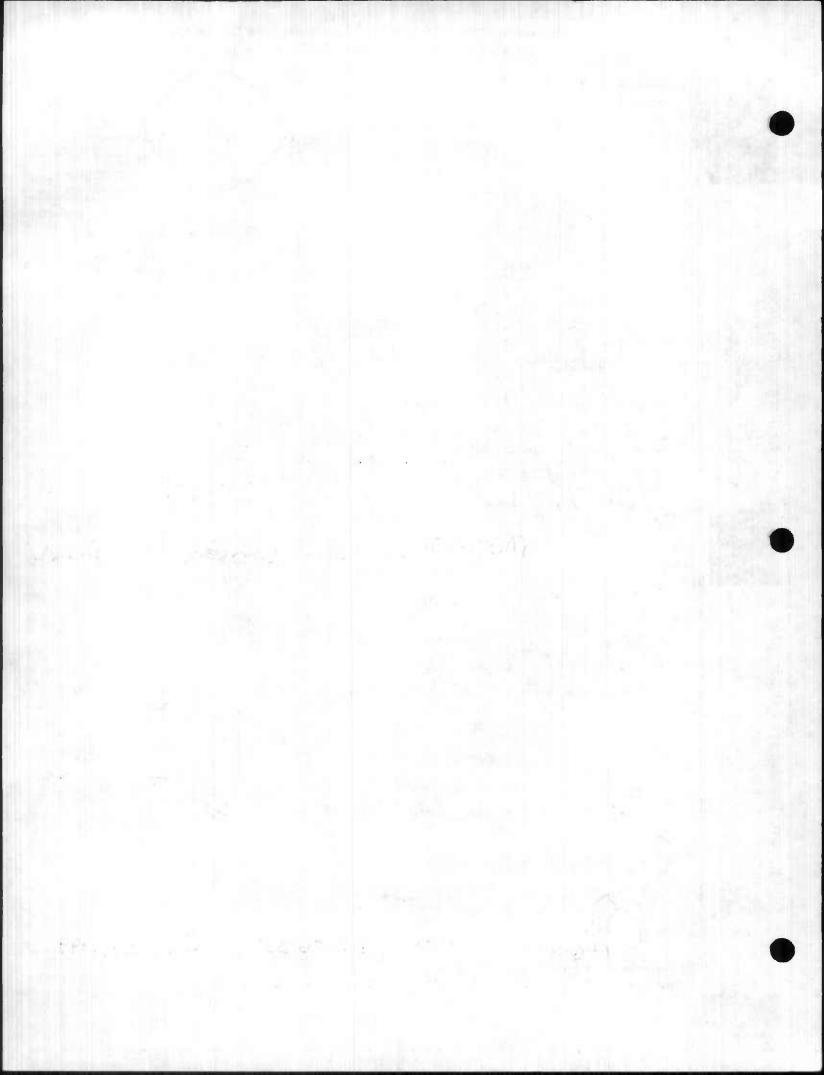
	Certificate of Death		Reg. No.		
	1. Decedent's Name (First, Middle, Last)	2. Date of D			3. Time of Death
ician dical	Robert Shuler Walleigh	July	24, 1999	Year 9	9:15PM
niner		or Location of Dea			
	Manor Care Chevy	Chase	Mont	tgomer	У
77	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24		irth	9. Birthplac	ce (State or Foreign
	027-07-8498 1™ 2□ F 84 Yrs. Months Days Hours M Usual Residence of Decedent	March 3	31, 1915	Washi	ngton, DC
	10a. State 10b. County 10c. City, Town or Location			10d	I. Inside City Limits
oto	Maryland Montgomery Chevy Chase				
놈	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Country	17
70	5701 Springfield Dr. 20816		U.S.	, A	
by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Ping Year or Dates: 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Ping Yes, Give Year or Dates:	? (Specify Yes or N uerto Rican, etc.)		ce - American ck, White, etc y: Whit	c.
ted	15. Decedent's Education 16a. Decedent's Usual Occupation	unding	16b. Kind of B	usiness/Indu	stry
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use ratined)	ногину	George	Washi	ngton
Som	4 Administrator		Univers	sity	
Be		Nama (First, Middi	le, Maiden Suman	ne)	
10	Charles Henry Walleigh Marth	a Matilda	a McDanie	21	
15	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number of	r Rurel Route Num	ber, City or Town	State, Zip C	oda)
	Catherine C. Walleigh-Wife 5701 Springfield Dr.	, Betheso	la, MD 20	0816	
	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location		n, State
	1 🗆 Burial 2 Dicremation 3 🗆 Hemoval from State	7/20/00	F-11-	Chamal	L 77 A
	4 Donation 5 Other (Specify) National Crematory 21. Signature of Funaral Service Licensee 22. Name and Address of Facility	7/28/99	Falls	Churci	n, VA
	Thomas E. Honobaker NW Washington, De		5130 W	Lscons:	in Ave.
	23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each lina.	diac or respiratory	arrest,		oproximate
an	shock, or heart failure. List only one cause on each lina.			lr C	nterval Between Onset and Death
al	Immediate Cause (Final				
er	disease or condition resulting in death) Pulmonary Fibrosis			15	Years
100	Due to (or as a consaquence of):				
를	b .				
Examiner	Sequentially list conditions, if any, leading to immediate				
	Sequentially list conditions, if any, laading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated awants Due to (or as a consequence of):				
edicai	that initiated avants resulting in death) Last Due to (or as a consequence of):				
Σ					
an/	U				
SIC	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Di	d tobacco uss co	ontribute to ti	he causs of death?
Physician/		10	Yes 2X No	3 ☐ Probe	bly 4 Unknown
by				T	
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ledicai	and manner stated.	rosumou at the tilli	o, outo and place,	2110 000 10 11	04004(8)
Medical Certification: 1	29b. Signature and title of certifier 29c. License number		29d. Date signe	ed (Month, Da	ay, Year)
	Thomas CHOWO (ha) DC6104		July 2	7. 199	9
	30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print)		0019 2	, 200	
	Thomas C. Havell II, MD., 4201 Cathedral Ave. NW, W.	achinatar	DC 200	216	
		asii Tiig coi	., 20 200	010	
State	31. Date filed (Month, Day, Yaar) 32. Registrar's Signatura				

treating the same

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State of Maryland / Department of Health and Mental Hygiene 9 9 25 | 88

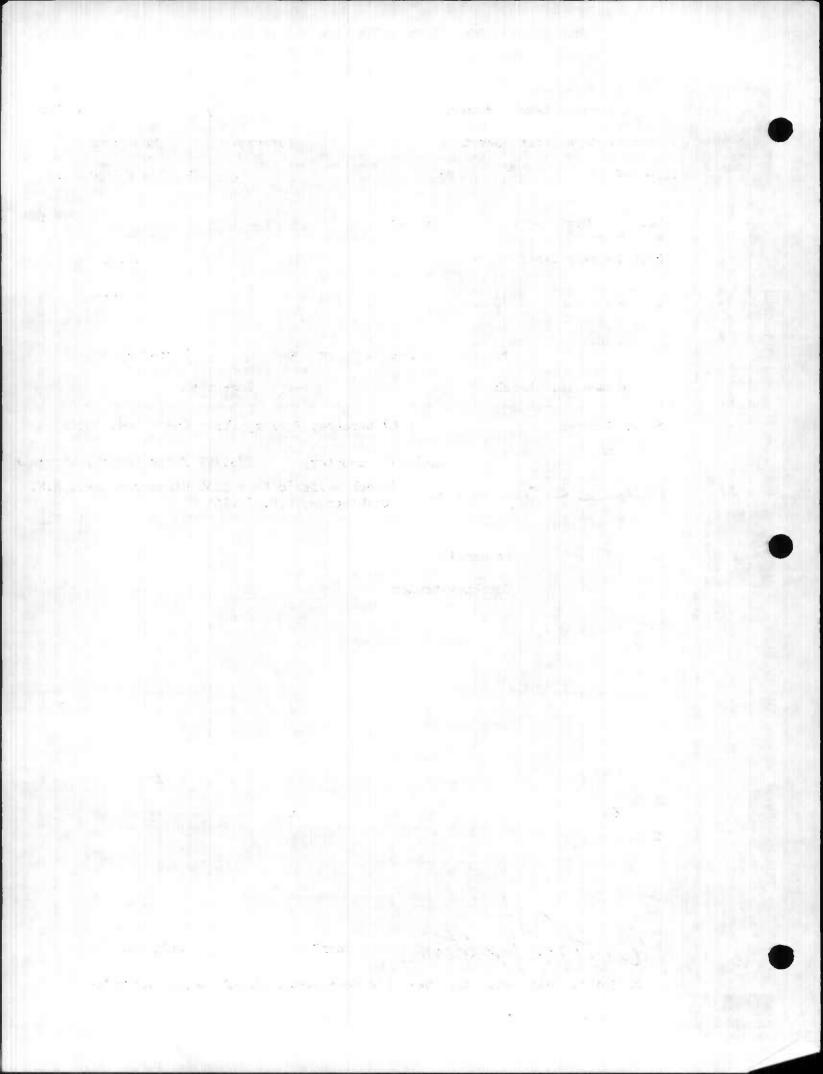
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	1. Decedent's Name (First, Middle, Las	e)				2.	Date of De			3. Time of Death	
Physician	Oi-Lyen Wang						Month July	28, 1	999	6:35am	
/Medical Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, To	own, or Local					
Examiner	7432 Damascus Roa				Gaith	nersbu	ro		gome	rv	
	5. Social Security Number 6, Se		last hirthday)	If Under 1 Year	If Under		Date of Birt		0		
Funeral		DM 201F 55		Months Days	Hours	Min.	(Month, Da	y, Year)		place (State or Foreign ntry)	
Director	Usual Residence of Decedent					N	iov. 5	, 1943	Hong	Kong	
Du A	10s. State 10b. County	10c. Ci	ly, Town or Lo	ocation					1	10d. Inside City Limits	
aho Jo	Md. Montgome	rv	Gaithe	rshurg						1 Yes 2 No	
or 28a-fall be notified Director	10e. Street and Number	-7						40: 00: 41	12.10		
Dir oc	10e. Street and Number			10f. Zip Code				10g. Citizen of \	What Cour	ntry?	
123 E	7432 Damascus Road	1		2088	2			United			
11.2.1.5-UO2U within 72 hours after death with the Maryland ene. then 'returel', or Neme 23s or 28s-f show he had cee Exeminer must be notified at empleted by Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of his Yes, specify Cub.	lispanic Or an, Mexica	igin? (Specif n, Puerto Ric	y Yes or No an, etc.)		e - Americ ck, White,	ean Indian, etc.	
S # 28 F		1 ☐ Yes 2 ☑ No If Yes, Give		1☐ Yes 2☐ No	Specify:		III	Specifi	Asia	an ·	
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od within 72 ho ygjene. wr then naturi ft, the tradical Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occup	pation	et of working		16b. Kind of B	usiness/In	dustry	
Die de	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	d)	K OF WORKING					
filed within Hygiene. then the the then then then then then t	12		Ca	shier				Reta	Retail		
The Hand	17. Father's Name (First, Middle, Last)				18. Moth	er's Name (F	irst, Middle,	Maiden Suman	10)		
Mental Me		Koi				Su-Fo	ng	Yar	ng		
Maryland d 2 should be file th and Mental Hy T Is marked othe Traumatic avent	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street	and Numb			er, City or Town	State, Zir.	Code)	
Te, Mar.	Peter Wang, husb			Damascus							
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Semit. Sepan mport my in	21. Signature of Funeral Service Licens	100	22	2. Name and Addre	ess ol Facili	be V	ol Fu	neral Ho	ome		
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Examiner	disease or condition resulting in death)	METAST	11110	- 610)~	Cu	· CEN		-	JWO4-P	
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To the Hospital or Attanding Physician 20 the Hospital or Attanding Physician Conference and Double to the Funeral Director: After the completely filled in by the funeral Medical Certification: 7											
To the Hospital within 24 hours To the Funeral completaly filled Medical Ce	29a. Certifier (Check only Indicate Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and my opinion, death occurred at the time, date end place,										
plet plet	one)										
To the com	29b. Signature and title of certifier			29c. Licens				29d. Date signe	d (Month,	Day, Year)	
	- And	~ ~	117	D35	6-	35		- ~ LL	29.	1999	
10	30. Nama and address of person who co	ompleted cause of death /Iter	n 23a) (Type	Print)				1			
	Dr. Joseph Kaplan			Phillip	Dr. C)Inev	Md 2	0832			
	31. Date filed (Month, Day, Year)	32 Registrar's Signa		1111111	22.		414.4				
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State of Maryland / Department of Health and Mental Hygiene 25 | 89

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xaminer	4a Fecility Nan	ne (If not institution,	give street and no	umber)				4b. City, Tov	m, or Lo	cation of Dee	th 4c. Co	unty of Dea	th	
	Mar	nor Care H	Health S	ervices				Pot	coma	С	Me	ontgo	mery	
ral	5. Social Securi	ity Number	6. Sex	7. Age (In yrs	s. last birthday) If Und Months	er 1 Year s Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year)	9. Birt	thplace (S	State or Foreig
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Completed by Funeral Director	10e. Street and	Number				10f. Z	ip Code				10g. Citizen	of What Co	ountry?	
ral Director	10714	Potomac 3	Tennis La	ane			2	0852			1	U.S.A.		
ne	11. Marital Stet	us	12. Was Dec	cedent Ever in	U,S. 13.	Was Dec	edent of h	lispanic Orig	in? (Spe	cify Yes or N Rican, etc.)	0- 14.	Raca - Ame Biack, Whit	erican Indi	an,
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70	H	Herman A.	. Reich					Sadye	e Re	osenth	al			
		's Name/Relationshi	lp (Type, Print)		19b. Mail	ling Addre	ss (Street	and Number	r or Rura	l Routa Numi	ber, City or To	wn, State,	Zip Code)	
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Physic /Med Exami

Funera Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumstic event, the Medical Examinar must be notified at PARKE.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1 December 11 10 10 10 10 10 10 10 10 10 10 10 10			Cert	ificat	e of L	Death		1000000	Reg. No.		
Decedent's Name (First, Middle, Le Dwavne Mont		Bias						2. Dete of De Month AUGUST	Dey	1999	3. Time of Deeth 8:59 PM.
4e Fscility Neme (If not institution, gir		5145			4	b. City, To	own, or l	ocation of Deat		unty of Deat	
SHOCK TRAUMA								IMORE		NA	
	NM 2□F	(In yrs. last b	irthday) Yrs.	If Under Months	1 Yeer Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, Da	th ay, Year)	9. Birt	hplece (State or Foreign untry)
218-80-3334 Usuel Residence of Decedent		38	113.					10-0	14-60		MD
0a. Stete 10b. County		10c. City, Tov	wn or Loca	ition				14			10d. Inside City Limits
MD NA		Balt	imor	ce							X Yes 2 No
100. Street and Number 1008 Shellban	ke Poad i	nt #3	Δ	10f. Zip	Code 225					of What Co	untry?
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Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X					1		pecify Yes or No o Rican, etc.)		Black, White	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give X Yeer or Detes:		1	Yes 2	2₩ No	Specify:			Sp	ecify: Bl	ack
15. Decedent's E (Specify only highest gro	ducation ade completed)	16a	Deceder (Give kir	nd of wor	rk done d	funing mos	t of wor	king	16b. Kind	of Business/	Industry
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Donald M.	Bias					Leo	ta		Car	roll	
19e. Informent's Neme/Reletionship (Zip Code) 21225
Donald Bias						anks	RC	ad Apt	:.#3A	Balt	imore,MD
20e. Method of Disposition 1 → Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Speci			ery, crema	tory or o	ther plac	cem.	08	Date 3-13-99		ion - City or ndall	Town, Stete
21. Signeture of Funeral Servica Lica	Elms	1				s of Fecilit	· E	Baltimo			and 21202 enue
23e. Pert1. Enter the disease, or comshock, or heart feilure. List only	plicetions thet caused one ceuse on each lin	the deeth. Do	not enter	the mode	e of dyin	g, such es	cardiec	or respiretory e	errest,	1	Approximate Intervel Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	· HUUTI	re Du	sopi	22						1	
	1	Due to (or as a	conseque	enca of):							
Sequentially list conditions, if any, leading to immediate	b	Due to (or es e	conseque	enca of):						1	
if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	C							_			
resulting In deeth) Last		Due to (or es e	conseque	nce of):							
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Pert II. Other significant conditions of	contributing to deeth bu	t not resulting	in the und	erlying ca	ause give	en in Pert I	l.	23b. Dld	tobacco ua	s contribute	to the cause of death?
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									an eutopsy ormed?		Were autopsy findings availeble prior to completion of cause
								8-1	/		of deeth?
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25. Wes case referred to medical examiner? \$\igcup \times	Hospitel:	nt 2 🔀 ER/O	utnationt	3 DO	Othe	er: _		th (Check only		Other (Cae	oih i
7. Menner of Deeth	28e. Dete of Injur	y 28b.	Time of		8c. Injury Work		JISING N	ome 5 Resi	how injury o	ccurred	
1 Neturel 5 Pending investigatio	0 0 1	r ear)	720P	М	1 🗆 `		No	Deiven	OFO	2, 1481	scrwith pole
3 Suicide 6 Could not be determined	building, etc.	ry - At home, f (Specify)	erm, stree	t, fectory	, office			City or To	Street and N wn, Stale)		Ural Route Number, HI.
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(Check only XX Medical Exar		examinetion er		stigetion,	in my of				date end pl	ece, and due	

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

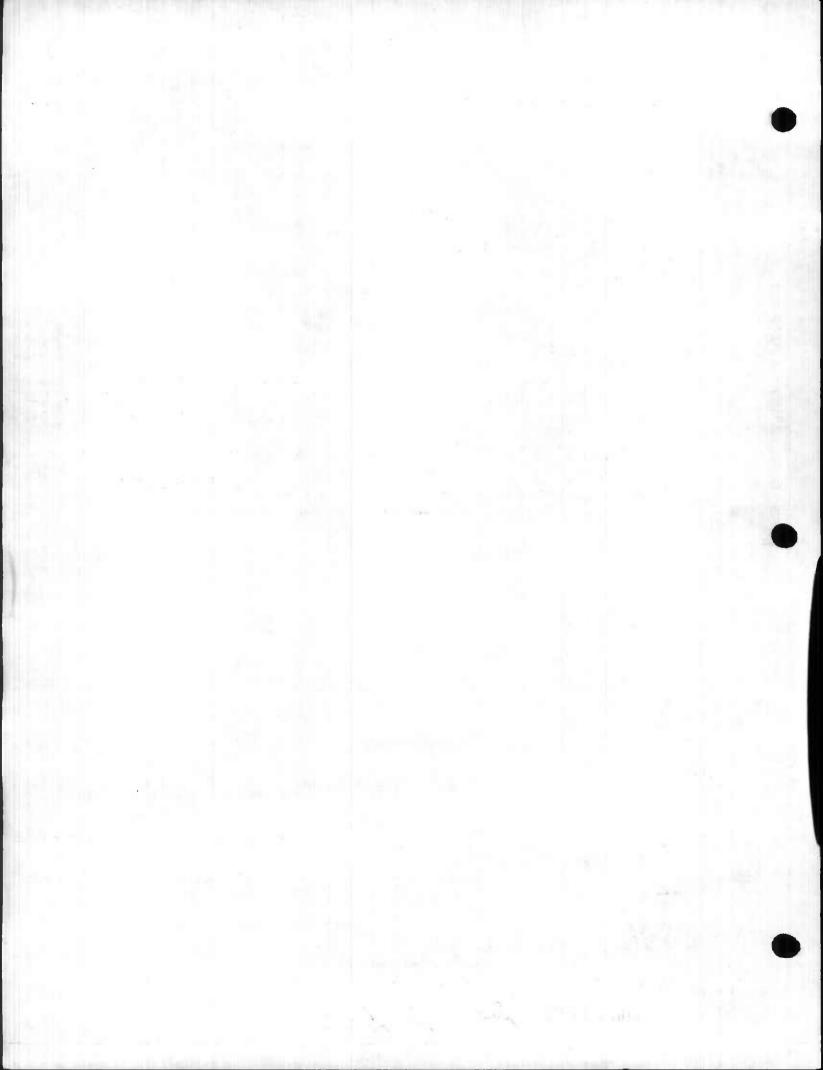
111 Penn S

31. Date filed (Month, Day, Year)

32. Registrer's Signeture State AUG 1 1 1999 Registrar

111 Penn Street, Baltimore, Maryland 21201

Spark



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 12-30 P BARNES GAZELLE 08-07-99 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE If Under 24 Hrs. 8. NURSING NIA IRVINGTON KNOWS HOME 5. Social Sacurity Number If Under 1 Year 6. Sax Birthplace (State or Foreign Country)
 A 7. Age (In yrs. last birthday) 10 M 20 F Days Months Hours Min. 82 216.28.2045 Yrs. PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? EZ ATHOL 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1□ Yes 2₽No Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TH GRADE IECHNICIAN NA HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SMITH HOLT JONES HABRY ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 DONALD JONES GREENLAWN RD. BALTO . mo. SON 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, State ING MEMORIAL 8-12-99 KANDAUSTOWN. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart future. List only one cause on each line. mp Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 1800 Sclesa Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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or Herna 23a

"natural"

d 2 should be filed within; th and Mental Hygiene.
7 Is marked other than "r

permit. Pages 1 and 2 Department of Health a Important: if item 27 la any injury or other tra

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

the Maryland

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Be Completed To Certification:

the buriel-transit 8 guipa etten o signed by this certificate has been signeral director, page 2 should be To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certificat completely filled in by the funeral director, it

Records, P.O. Box 68760.

Division of Vital

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifies H Llacem MI

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

HEEM, 500 PIND of phin Str

32. Registrar's Signatur

Registrar

Medical

ARVISER OF

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2 Date of Death **Physician** Month Dorothy Bichy Elaine August de /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Brooke Grove Rehabilitation and NUrsing Center Sandy Spring Montgomery If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 20XF Months Yrs. 79 Director 220-05-3573 1920 Maryland Usual Rasidence of Decadent the Maryland Show 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23a or 28a-f show the Mexical Examiner must be notified at 1 Yas 2 No Director Maryland Montgomery Olney 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter deeth with 20832 4020 Mt. Olney Lane USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Giva Year or Dates: Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - Amarican Indian, Black, White, atc. 11. Marital Status 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) th end Mental Hygiene.
7 is marked other than treumatic avent, the Men College (1-4or 5+) Homemaker Own home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 end 2 should be fil ment of Health end Mental H tant: If Item 27 Is marked oth jury or other treumatic aven Be George Flock Nellie Smith 19a. Informant's Neme/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas L. Bichy / Son 4020 Mt. Olney Lane, Olney, Maryland 20832 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny Injury or 4 ☐ Donation 5 ☐ Other (Specify) 8-9-99 Loudon Park Cemetery Baltimore, Maryland 21. Signatura of Funeral Sarvica Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Par / Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, show or heart failure. List only one cause on each line. Approximate Intervat Betw Onset and Death **Physician** /Medical tmmedlete Ceuse (Final · ACUTE RENAL FAILURE DAYS disease or condition resulting in death) Examiner Due to (or es a consequence of) Physician/Medical Examiner DEHYDRATION The law requires that the death certificate be axecuted or use es the bunel-transi Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or tripiny that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760. C. EXACERBATION OF CHRONIC OBSTRUCTIVE Dua to (or as a consequence of):
PULMONARY DISEASE (COPD) CHRONIC OBSTRUCTIUS PULMONARY DISEASE YEARS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS; URINARY TRACT Records, þ pege 2 should be Be Completed 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performed? INFECTION; VASCULAR DEMENTIA certificate hes 1 Yes 2 2 No 1 Yes 2 No of Vital Physician: 25. Was cese referred to medical 26. Place of Deeth (Check only one) al or Atten.
Aus effer death.
Areal Director: Affer this ce Other: 4 Nursing Home 5 Residence 6 Other (Specify) Jo 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending Investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital o within 24 hours of To the Funeral D completely filled i 19 Certifying Phyalcian: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier 29b. Signatura and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) August 06, 1999 - STAPF PHYSICIAN and address of person who completed ceuse of death (Item 23a) (Type, Print) 20860 GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MARY LAND 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

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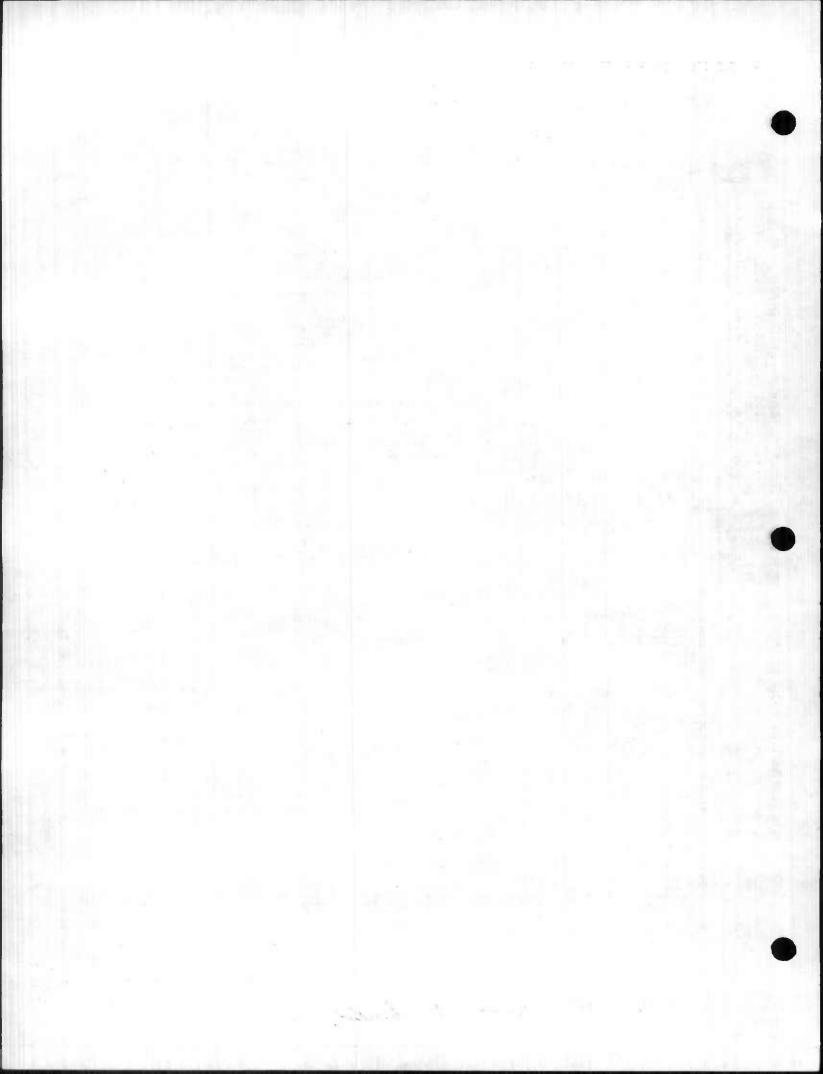
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	Physici /Medio		Mary Teresa Brender	August	6, Dey 1999	Yaar	3:50 PM
3	Examir	ner	4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Loc	cation of Death	4c. County		
			Pleasant View Nursing Home Mt. Airy 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs.	- 5 - (5)	Carro		
	Funeral Director		Months Deys Hours Min.	8. Deta of Birth (Month, Day, Oct. 2,	1905 I	9. Birthpla Country Mary 1	ce (State or Foreign y) and
	show		10a. Stata 10b. County 10c. City, Town or Location			100	d. Inside City Limits
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	or 28	Director	10e_Street and Number 3383 SONIA TRAIL 10f. Zip Code 21043	1	0g. Citizen of W	hat Country	y?
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ary		2	Charles Brender Anna Kroe 19e. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural	9	City or Town 5	Steta Zin C	iode)
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Baltimore,	permit. Pages Department of Important: If It any Injury or once.		22. Signature of Funeral Service Licensus 22. Neme and Address of Facility Hubbard Funeral Home	. Inc.			
	40260		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	Baltin	nore, Ma	rylan	d 21229
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardled or shock, or heart failure. List only one cause on each line.	raspiratory arra	ast,		Approximata ntarval Between Onset and Death
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	To the Heapital or Attending Ph within 24 hours after death. To the Fureral Director: After th completely filled in by the funeral	edical C	29a. Cartifler (Check only one) 15 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end piece, at a companient of the co	nd dua to the ce d et tha tima, de	euse(s) and mar ata and place, a	nnar as stet nd dua to th	ed. na cause(s)
	To th To th comp	×	29b. Signetura and title of certifier 29c. License number		9d. Dete signed		
			N. a lallandi D. 30469	1	thgust	. 7	m, 1999
			30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) N'13. VELLAN 9055, CHEVROLET DRIVE: #100, ELLICOTT CITY	17 <r< td=""><td></td><td></td><td></td></r<>			
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AMENDED	ITE	M #24a PER G774 8/11/ 1. Decedent's Name (First, Middle, L			Certifica	te of	Death	2. Date of De	Reg. No.	<u></u>	3. Time of Death
Physic /Medi		CATHERINE :		NONI				Month 8	Day	49	1238
) Exami		4a Facility Name (If not institution, go University Hosp		r)	-	1	lb. City, Town, or Baltimo		h 4c. County	of Death	
Funeral Director		5. Social Security Number 219–12–3028 6.	_ \	Age (In yrs. last b 76	Yrs. If Und Month	er 1 Year Days	If Under 24 Hrs Hours Min.		ly, Year)		ace (State or Foreign ny) ylvania
2		Usual Residence of Decedent 10a. Stete 10b. County		10c. City. Tox	wn or Location						d. Inside City Limits
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cher death with the Marylan or Items 23a or 25a-f show miner must be notified at	al Director	10e. Street and Number 7302 Family Acr	es Road		101. 2	ip Code 21	076		10g. Citizen of V USA	What Count	ry?
-0020 hours after dea hursif, or itserns at Examiner, m	by Funeral	11. Merital Stetus 1 □ Never Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Deceder Armed Force: 1 Yes 2 H Yes, Give Yeer or Detes	s? ₹No		edent of Hecify Cubs	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rac Blac Specify	e - America ck, White, e	itc.
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Aar 2 sho		19a. Informent's Neme/Reletionship	State, Zip								
		Linda Wagner (D 20a. Method of Disposition	aughter)	20b. Place	of Disposition (N	ame of	cres Roa	d, Hano	ver, MD		
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Baltimore, permit. Pages 1 ar Department of Hea Important: if Hem 3 any Injury or other ance.	dus dus	21. Signature of Funeral Service Lige		10	Har	desty	ss of Facility Funeral				
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Physician /Medical Examiner	er	Immediate Cause (Finel disease or condition resulting in death)	· Cora	Due to (or as a	PATERY consequence of	0(:	SEKSE				Onset and Death
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- 0 0 2	Physician/M	Pert II. Other algolificant conditions	contributing to death	but not resulting	in the underlying	cause giv	en in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
P. hat the delay detac	by Phy	DURING CORON	JARY MR	TERY E	BYPASS	, UN	ABLE	1)	Yes 2 No	3 Prob	ebly 4 Unknown
2 s g	2 should	TO SEPARATE	FROM !	HEAPT-	LUNG	MAC	HME	24a. Was perf	s an autopsy ormed?	con	re autopsy findings ilable prior to apletion of cause leath?
_ F # a									Yes 201 No	10	Yes 2□ No
	o Be	25. Was case referred to medical axaminar? 1 2 Yes 2 No	Hospitel: 1 topa	tient 2 ER/O	utpetient 3 0	Oth Oth	er	ath (Check only	one) idence 6 □Ott	er (Snerih	1
	ation: T	27. Manner of Deeth 1 Natural 5 Pending 2 Accident Investigation	28e. Date of In (Month, D	jury 28b.	Time of Injury	28c. tnjur Wor		1	how injury occur		
2 24 4 5	Certification:	Suicide Sui							(Street and Numb wn, State)	per or Rural	Route Number,
To the Hospital Within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 ☐ Certifying P 2 ☐ Medicat Exa	hysician: To the bes miner: On the basis and menner:	of examinetion as	e, death occurre nd/or investigation	d at the tin	ne, date and place pinion, death occ	a, and due to the urred at the time,	cause(s) and ma date and place,	anner as sto and due to	ited. the cause(s)
To the within 2 To the comple	M	29b. Signature and title of certifier Furt Webby	y, Resid	ent	2	9c. Licens DL	e number 16536		29d. Date nigne	d (Month, I	lay, Year)
		30. Neme and address of person who	completed cause of RG, M.P.	death (Item 23a)		ANIV	me Hospi	m, 22	S. CREE	NEST.	MO 217
Sta Registi		31. Dete Hed (Month, Day, Year)	32. Regis	trar's Signeture	Sport	21					



State Registrar

AUG 1 1 1999

31. Dete filed (Month, Dey, Year)

PESTANER M.D.

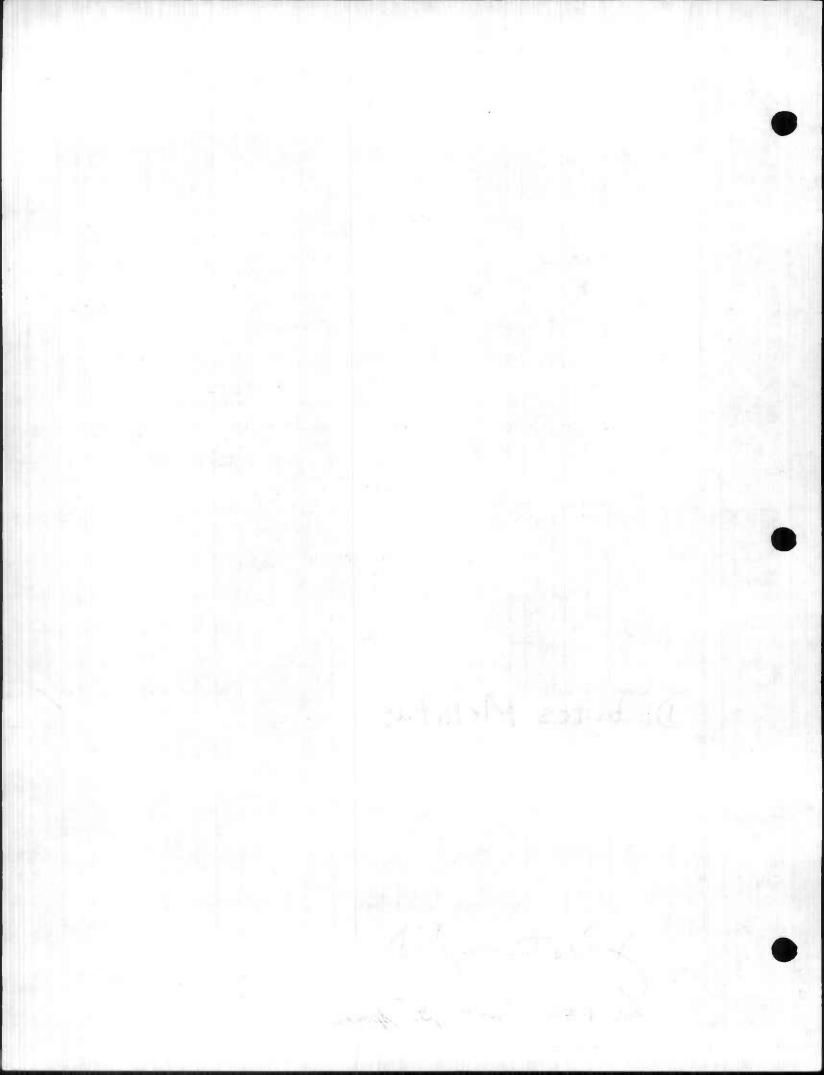
30. Name and addre JOSEPH

32. Registrar's Signature

is of person who completed cause of death (Item 23a) (Type, Print)

ook

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death AMENDED ITEM #24a PER FH G775 9/1/99 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 AM 11) ARY ELLEN C. Cipolloni

4a Facility Name (If not institution, give street and number) Month **Physician** AUGUST /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner CANTON HARBOUR MURSING CENTER JOANTO,

Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Months) Days Hours Min. (Month, Day, Year) 17 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 2 Yrs. 219-22 8592 Director Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f ahow must be notified at JETYes 2□No Director MD BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 239 21202 USA ALBEMARLE Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married *natural", or h 21215-0020 Specify WHITE 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMENAKER Baltlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental I int: If item 27 is marked or MOHN REDMOND MARION SchoolDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 239 ALBEMANE ST. BALTO, Md 2/202 PRANK Cipo LLON! (HUSBAND)
20a. Method of Disposition or other 8 Pate 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stete 1-Burial 2 ☐ Cremation 3 ☐ Removal trom State Department Copartment Important: If any Injury or once. 4 Donation 5 DOther (Specify) GARDONS of FAITH BALTO, Md 21. Signeture of Funeral Service Lie 22. Name and Address of Facility

DELLA NOLE + SCNS FUNCAR HOME 322 SitiCH STO Borto. MJ. 21202 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate triterval Between Onset and Death **Physician** RENAL FAILURE

Due to (or as a consequence of): /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner SEVERE NEPHROSCLERASIS Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): HTPENTENSIVE CANDIOVASCULAR DISEASE Box 68760. Due to (or as a consequence of): Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? DIABETES 1 Yes 2 No 3 Probably 4 Unknown MELLITUS þ MULTIPLE DECUBITI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital or Attanding Physician: ours after death.

Bral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No edicai Certification: To 28a. Date of trijury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

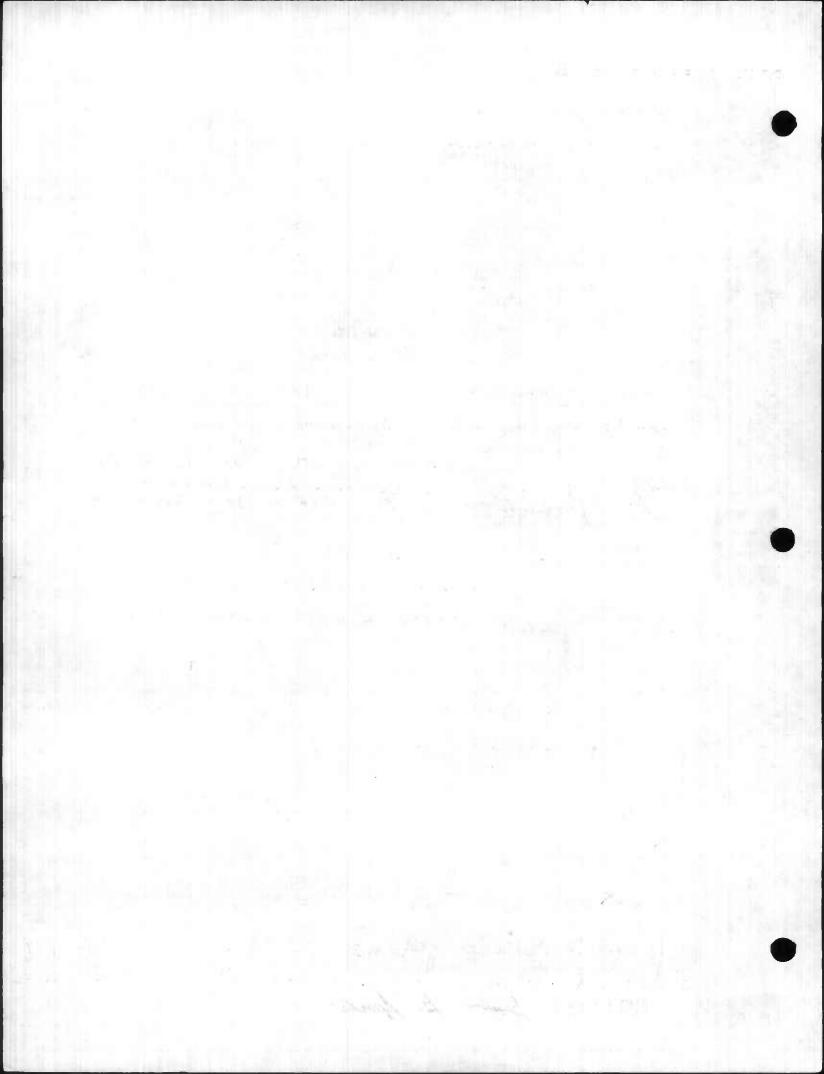
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D07316 AUGUST 9. 1999

State Registrar

C 493

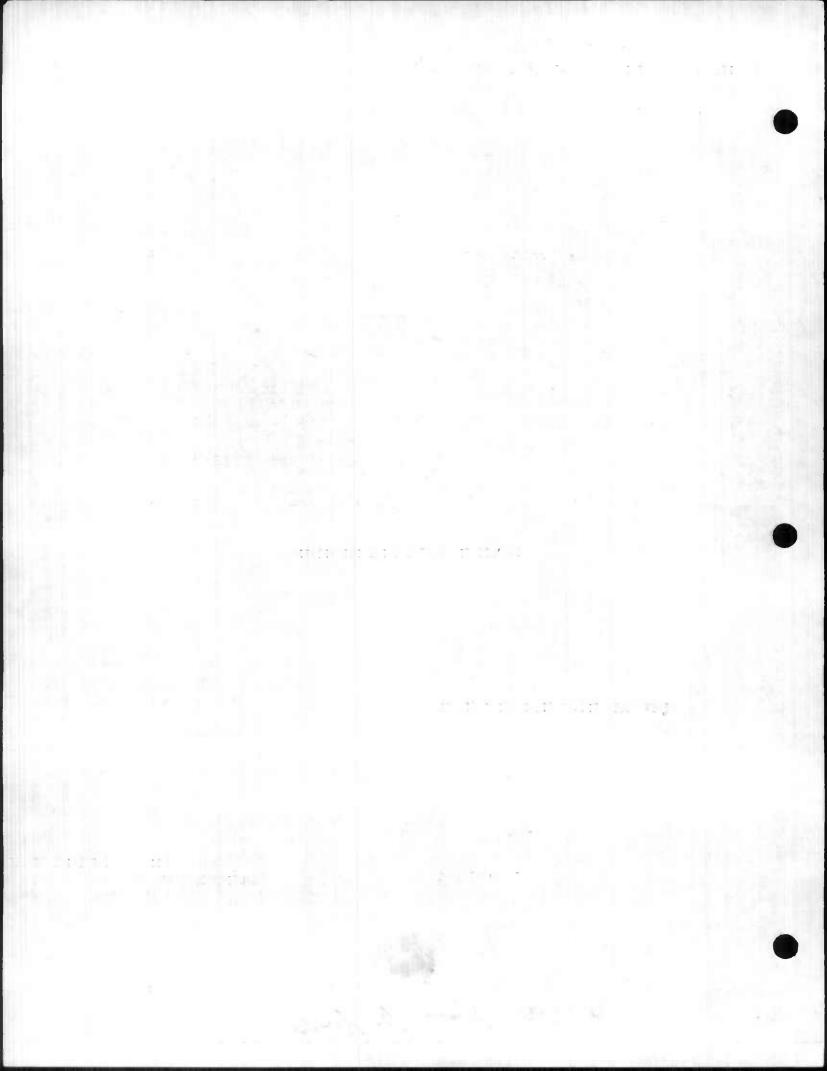
32. Registrar's Signature

e and address of person who completed cause of death (Item 23a) (Type, Print) NOTARANGELO M.D. 301 ST. PAUL PLACE BALTIMONE 21202



DHMH 16 Rev 6/95

ORIGINAL

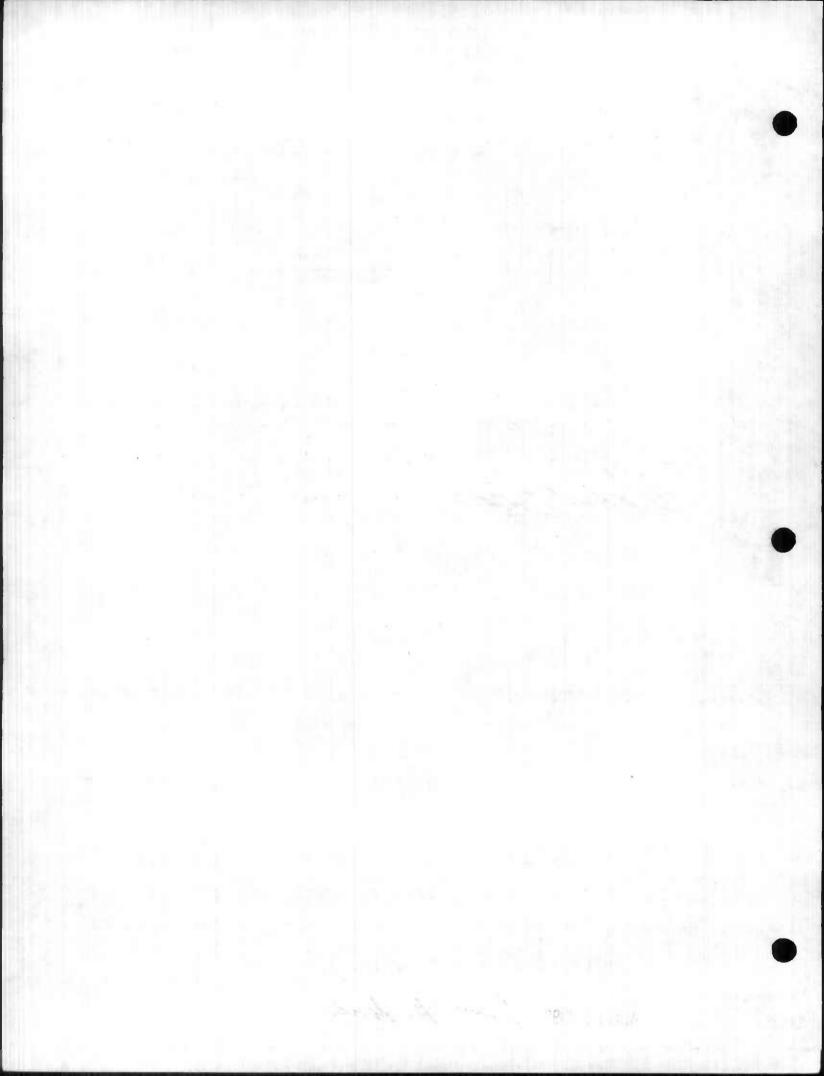


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Q Q 25 | 98

				Certificate of	Death	Reg	. No.) 20	100
	1. Decedent's Name (First, Middle, L.	est)		1000		2. Date of Death Month		Year 3.	Time of Death
Physician /Medical	BESSIE			DAV	15	AUGUST 9	Day 1999		0:30 PM
Examiner	4a Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or L	ocation of Death	4c. County		
	NORTH OAKS HEAL	TH CENTER			BALTIMOR	E	BALT	IMORE	
Funeral Director	213-52-8960	Sex 7. Age 1 □ M 2X F	(In yrs. last bii 96	thday) If Under 1 Year Montha Days		8. Date of Birth (Month, Day, Y	(ear) 1903	9. Birthplace Country)	(State or Foreign
Pu a	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d. In	nside City Limits
f sho	MD N/A		BALTI						¥Yas 2□No
vith the Mer to cr 28a-fal be notified Director	10e. Street and Number		DAGES	10f. Zip Code		100	. Citizen of V	What Country?	
deeth with the Merylar tm st 28 or 28a-f show if must be notified at	6318 GREENSPRI	NG AVENUE	#202	1 200	21209		U.S.	Α.	
ar, or he removed	11. Merital Stetus 1 Never Merried 2 Married 380 Widowed 4 Divorced	12. Was Decedent II. Armed Forces? 1 Yes 2 Y N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cul		pecify Yes or No- Rican, etc.)		e - American Inck, White, etc.	dien, WHITE
within then.	15. Decedent'a E (Specify only highest gr Elementary/Secondary (0-12)		+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin IEMAKER	during most of work	cing 16	b. Kind of Bu	usiness/Industry	,
EISE a	17. Father's Name (First, Middle, Las.	"	1101	ILA IAICLIC	18. Mother's Nam	e (First, Middle, Ma			
D See	BENJAMIN		RARTN	OWITZ	DORA			(UNKNO	WN)
and Men e marke aumatic	19e. Informent's Name/Ralationship	(Type, Print)		. Meiting Address (Stree		ral Route Number, C	City or Town,		
27 le	SHIRLEY SILVER	/ DAUGHTER	1	POMONA EAS	T #409 -	BALTIMOR	E. MD	21208	
0	20e. Method of Disposition		20b. Place o	Disposition (Name of ry, cremetory or other pla				City or Town, S	State
mt: H my or	1 Na Burial 2 Cremation 3 C 4 Donation 5 Other (Speci			SHALOM MEM.		/11/99 F	REISTER	RSTOWN,	MD
Department Important: any Injury	21. Signature of Fundal Service Lice	0000		22. Name end Addr	ess of Facility S STERSTOWN	OL LEVINS			
	23a. Paff1. Enter the disease, 200 shock, or heart failure. List only	meating that caused	the death. Do	1				App	roximate rval Between
op physician and as the bunet-trensit Aedical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or as a Hybl	consequence of): V A VEV consequence of): V H 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	disco	Can-			
	resulting in death) Last	(Duces	Live hea	VI lail	hyl			
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d by the attending etached for use a Physician/M	Part II. Other algnificant conditions	contributing to death bu	t not resulting in	n the underlying cause g	iven in Part I.	23b. Did tobe	occo une co	ntribute to the	cause of death?
igned by the attendii be detached for use by Physician/I	Hypothy	roidin.		7.76		1 T Yes	2000	3 Probably	4 ☐ Unknown
should should	1. Depre	15/04				24a. Wes an a parforme	autopsy id?	available	utopsy findings e prior to tion of cause n?
ribis certificate he eral director, page						1 ☐ Yes	2 5 No	1 🗆 Yes	s 2□ No
Betor B	25. Was case referred to medical examiner?	Manager			~	th (Check only one)			
T gg	1 Yes 2 No	Hospital:		tpatient 3LI DOA		ome 5 Resident			
octor: After by the funer iffication:	27. Menner of Death 14SNetural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b.	Firme of njury 28c. tnji		28d. Describe how	injury occur	red	
rs after death. al Director: After ted in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	On Dian of lair	ry - At home, fa . (Specify)	m, street, factory, office	Yes 2 No	28f. Location (Stre City or Town,		per or Rural Rou	ite Number,
within 24 hours after death. To the Funeral Director: After completely filled in by the funer medical Certification.	(Check only 2 Medical Example 1997)	miner: On the basis of	examination an	, death occurred at the t d/or investigation, in my					
within 24 hours To the Funeral completely filled Medical Co	29b. Signature and fittle of certifier	and manner sta	ted.	29c. Licen	se number	290	I. Date signed	d (Month, Day,	Year)
¥ 1 8	•	WIN		A	3032	i i	08	10/9	9
	30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print) OCd	Court Ro	1. Balt	more,	170 2	1208
State	31. Date filed (Month, Day, Year)	32, Registra	r's Signature	11	,	1	1		

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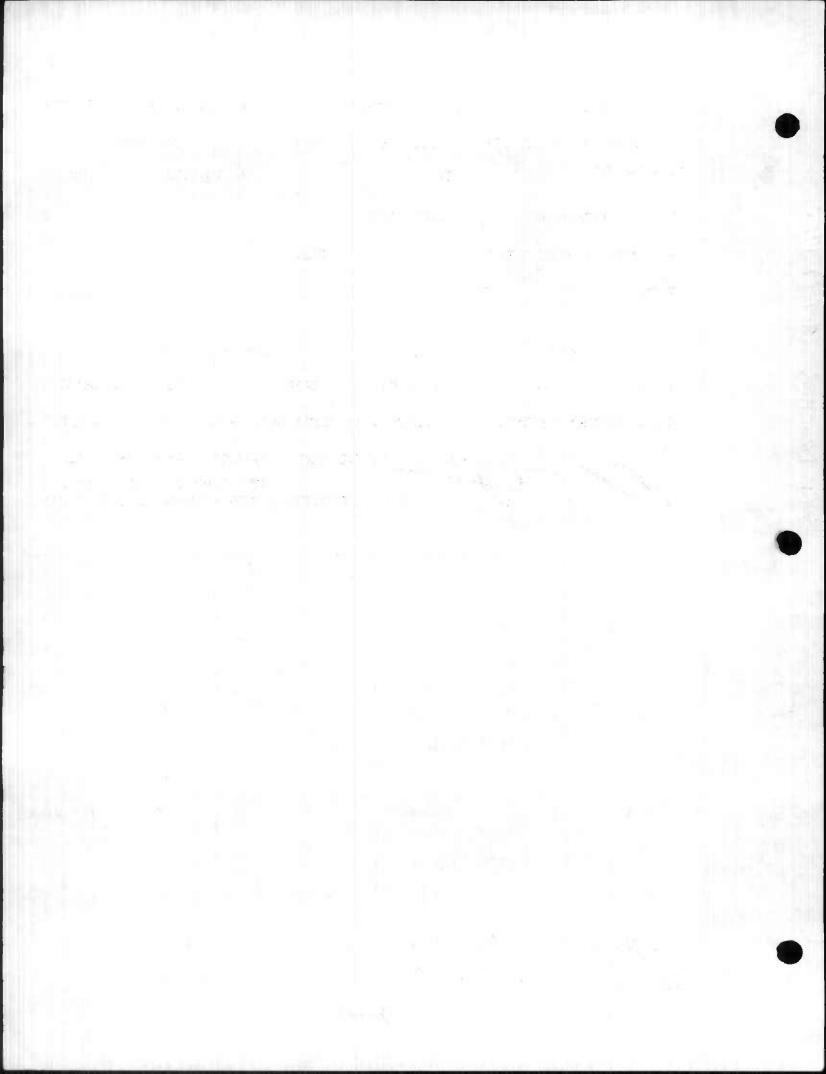


				or maryia.	(epartment of I Dertificate of	Death		Reg. No.	2	5199
Physic /Med		1. Decedant's Name (First, M BARI		J.		DRUCKER		2. Dete of Dec Month AUGUST	Dav	Yeer	3. Time of Death 1705PM
Exam		4a. Facility Name (If not instit			ALTIM	IORE	4b. City, Town, or L TOWSON	br Location of Deeth 4c. County of Deet BALTIMOR			
Funera Directo		5. Social Security Number 219–82–9709	6. Sex 1 ☐ M 2 【X F	7. Age (In yrs.		Months Devs		8. Date of Birt (Month, De) JAN.10,	y, Yaar)	9. Birthple Count	eca (State or Foreign ry) MD
Maryland fahow	Joi	Usuel Residence of Decedan 10e. State 10b. Cor MD BAI				or Location MILLS				10	od. Inside City Limits 1 ☐ Yes 2 💆 No
h with the I	al Director	10e. Street end Number 2208 SHADED				10f. Zip Code	21117	10g. Citizen of What Country? U.S.A.			
215-0020 hin 72 hours after death with the Maryland e. n "natural", or items 23s or 28s-f show Medica: Exam ner must be notified at	d by Funeral	11. Meritel Status The status The statu	Armed Married 1 ☐ Ye If Yes, ced Yeer or	ecadant Evar in U Forces? s 2 No Give r Detes:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yas 2 No	Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Specify		WHITE
2121 od within gjene. or than	Completed	15. Dace (Specify only hi Elementery/Secondery (0-1	NONE	d) e (1-4or 5+)	(0	ecedant's Usual Occuj Sive kind of work done fe. DO NOT use ratire	during most of work d)		NONE		ustry
E 0 = 0 >	To Be	THOMAS	Α.		DRUC		18. Mother's Nam	P	EARL	SAL	GANEK
ore, M es 1 end 2 of Health of fitem 27 is		19a. Informent's Neme/Ralat THOMAS DRUCK 20a. Method of Disposition 1 [X] Buriel 2 Cremati 4 Donation 5 Othe	ER / FATHE	m Stete	220 Pleca of D cemetery,	Asiling Address (Street OB SHADED E isposition (Neme of crametory or other ple MEMORIAL	BROOK DRIV			LS, M	D 21117 vn, Stete
Daltimorent Peg Department Important: I any injury o once.		21. Signature Funeral en	los Liofrises	7		22. Name end Address	S	OL LEVIN			
Physician /Medical Examiner		23e. Part1. Enter the disease shock, or haart failure. Immadiate Ceusa (Final disease or condition resulting in death)				A aspensequence of):					Approximate Interval Batween Onset and Death
BOX DO/DU, eath certificate be executed ettending physician and I for use as the buriel-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initietad avants resulting in death) Lest	6			sequence of):					
S, F.C. is that the d	by Physician/M	Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Congenital vibella Syndrome							23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4		
aw requi	ompieted	J						24e. Was a	en autopsy med?	com	re autopsy findings ileble prior to apletion of cause eath?
OT VICAL HOPASSIGN: The light certificate he rail director, page	o Be Con	25. Wes case rafarrad to med axaminer?	Hospital:			Ott	26. Place of Dea		ne)		Yas 2□No
OIVISION OT after deeth. Director: After this in by the funeral di	Certification: To	3 ☐ Suicide 6 ☐ Co	28a. Del	Inpatient 2 te of Injury onth, Dey Year)	28b. Tim Inju	e of 28c. Injury	ry at		ence 8 SOther		11.0
To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune fune.	edical Certi	29a. Certifier (Check only 2 Medi	fylng Physician: To ti cal Examiner: On the	Iding, etc. (Special he bast of my known basis of examine	y) wledge, d	aath occurrad at the ti	me, dete end plece ppinion, death occur	City or Tow	m, Stete)	nner ss sta	ited.
To the within 2 To the comple	-	29b. Signeture end title of cer 30. Name end eddrass of pers A A C (e) 31. Data filled (Month, Day, Ye	end me	enner stated.		1 22 1					
St Regis	ate	31. Data filed (Month, Day, Ya AUG 11	7 GBMC	Registrar's Signs	ature 4	. Charles .	It. Bal	ets. m	9 515	20	

DHMH 16 Rev 6/95

8-9-99 1705

BARI DRUCKER



State of Maryland / Department of Health and Mental Hygiene

			State of Maryland		ficate of			leg. No.	25	0200
	Physician	Decedent's Neme (First, Middle, Last	Contract Con				2. Date of Dea Month		Year	3. Time of Death
i,	/Medical	Mildred		ASH		th City Town	Augus		99	9:40 Am
	Examiner	4e Facility Name (If not institution, give St. Elizabeth's	· ·		1	Baltimo	r Location of Death	4c. County o		
-	Funeral	5. Sociel Security Number 6. Se			If Under 1 Year	If Under 24 Hr	S. B. Date of Birth			nce (State or Foreign
	Director	212-09-3528	M 2₽F 83	Yrs.	Months Deys	Hours Mi	AUG . 4	1916	Mar	yland
	A g M	10a. Stete 10b. County	10c. City	, Town or Local	tion				10	d. Inside City Limits
	with the Marytan a or 28s-f show be notified at Director	MD N/A	Bal	timore						1X Yes 2 □ No
	e or 28e-f s be notified Director	10e. Street and Number		10g. Citizen of Wi	nat Countr	33				
	me 23e Limeth Jeral [USA						
		11, Marital Status	12. Was Decedent Ever in U,S Armed Forces?	S. 13. Wa	s Decedent of H es, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race Black	 Americal White, et 	
Maryland 21215-0020	Example by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:	10	Yes 2 1 No	Specify:		Specify:	wh	nite
5-0	ed within 72 ho ygiene, ar than "natura", t, the Medical Completed	15. Decedent's Edu (Specify only highest gred	cation e completed)	16a. Deceden	nt's Usuel Occup	ation during most of w	orkina	16b. Kind of Bus	iness/Indu	stry
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d 2				A	ssistan	t Manage	ame (First, Middle,		C. Mu	irpny
lan	id be fi						rie A. 0'			
ary	and M man	19a. tnformant's Neme/Reletionship (T)	pe, Print)	19b. Meiling	Address (Street		Rural Route Numbe		itate, Zip C	Code)
1775	and 2	Melvin H. G. Dash	, Jr nephew	6459	Loudon	Ave., El	lkridge.	Md. 210	75	
ore	T He w	20e. Method of Disposition 1	20b. Pl	ece of Dispositi emetery, cremet	on (Name of tory or other plea		Dete	20c. Location - C		m, Stete
E	Pag ment luny o	4 Donetion 5 Other (Specify)	Ne	w Cathe	dral Ce	metery	8/13/99	Baltimo	re, M	1d.
Baltimore,	Depart Depart Import any in	21. Signature of Funerel Service Licens		Gar	y L. Ka	ufman Fu	uneral Ho	me @ Mead	owri	dge MP, Inc.
		23a. Part1. Enter the disease, or compl	icetions thet caused the deeth.				Lvd., Elk		: /	21075 Approximate
5	Physician	shock, or heert feilure. List only o								Interval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition	Due to (or GENE RAL	SE M.	Iti-IA	UFARCT	Deme	NTIA	10	5 YEARS
в		resulting in deeth)	Due to (or	as e conseque	nce of):					
	executed n and ial-transit		GENE RAL	red	ATG	erosc	(erosi	5	1/	O YEARS
ć	execu in and ial-tra	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	es e conseque	nce of):				1	,
68760,	ficate be executed 3 physician and as the burial-transit edical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	es e conseque	nce of):				-	
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Box	that the death cert ed by the attendin detached for use / Physician/M								1	
o.	the de sched is the sched is the sched in hysic	Pert II. Other aignificant conditions con	tributing to death but not resul	iting in the unde	erlying cause giv	en in Pert i.	23b. Did t	obacco use cont	ribute to t	the cause of death?
9	igned by be detected	Scuere ADRTI	L AND MITE	AL IA	SUFFIC	iency	101	res 212 No	3 Probe	ably 4 Unknown
Records,	The law requires that the death cert cate has been signed by the attending page 2 should be detached for use.	Chronic Renz	L FAILURE	. EAR	du GA	wareve	24a. Wes a	an autopsy med?	avai	re autopsy findings itable prior to apletion of cause
3ec	The law ate has b page 2 si	. 1	1	,					of de	enth?
alF	certificate har rector, page	Right FOOT. A	phasia. Dy	VSPHA	SIA		101		1 🗆	Yes 20N6
of Vital	Physician: this certific ral director,	25. Was/case referred to medical examiner?	lospitel: 4 Day 10 4 2 5		oClood Oth		eath (Check only o			
	Physic or this control or oral director	27. Menner of Death	28a. Dete of Injury	28b. Time of	3 DOA 28c. Injur		Home 5 ☐ Resid	ow injury occurre		
ion	Attending In death. octor: After by the funerification:	1 DNaturel 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury		Yes 2 □ No				
Division	5 4 5 5	3 Suicide 6 Could not be determined	28e. Plece of injury - At hor building, etc. (Specify)		, fectory, office		28f. Location (S City or Tow	itreet and Number n, State)	r or Rural	Route Number,
	Mospital 24 hours a Funeral I letely filled		atcian: To the best of my know							
	the Hospi in 24 hou the Funer pletely fill	(Check only 2 Medicat Examinate)	ner: On the basis of examinetiand manner stated.	on and/or inves	itigation, in my o	pinion, death oc	curred at the time, o	sate end place, ar	nd due to t	ne cause(s)
	To the Comple	29b. Signeture and title of certifier	7		29c. Licens			29d. Date signed		
	10	Therefact,) ATTENDIA			200	,	409057	- 18	1899
	MU	1	mpleted cause of death (Item	23a) (Type, Pri	nt)	· 100-	: /		. /	le, mp znze
	1 1/1	31. Date filed (Month; Day, Year)	32. Registrer's Signet	20-61	MAIDE	N CEO	CO LA	y ATON	SURI	E MD ILIZE
	State	The same that th	SE. Plagation & Oldinot	4	/.	1 ,				

DHMH 16 Ray 6/95



2DWAR!

Yrs.

7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death

)	Physic /Medi Exami	ical
	Funeral Director	
-	show	

7 is marked other than "natural", or items 23e or 28e traumatic event, the Medical Examinar must be notif

Hygiens.

Pages 1 and 2 should be filed v rtment of Health and Mental Hygin rtant: If Item 27 is marked other?

8

altimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

Examiner

Physician/Medical

P

Completed

Be

10

Certification:

edicai

Church Home Hospital 5. Social Security Number 6. Sex 250-52-6095 Usual Residence of Decedent 10a. Stete 10b. County MD NA

10e. Street and Number

ROSEANNA

4e Facility Name (If not institution, give street and number)

1046 Milton Avenue

69 10c. City, Town or Location Baltimore

10 M 20 E

If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months

AUG. 106/

4b. City, Town, or Location of Death 4c. County of Death

10f. Zip Code 10g. Citizen of What Country? 21215 USA 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.)

Baltimore

14. Race - American Indian, Bieck, White, etc. Specify: Black

300

10d. Inside City Limits

t Yes 2 No

MD

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 6th Grade

1 Never Married 2 Married

3☐Widowed 4☐Divorced

College (1-4or 5+)

1 Yes RNo If Yes, Give Yeer or Dates:

12. Wes Decedent Ever in U,S. Armed Forces?

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic

1 Yes 2 No Specify:

various trades

16b. Kind of Business/Industry

17. Father's Neme (First, Middle, Last)

Thomas

Raymond

20e. Method of Disposition

Hayes Green 19a. Informent's Name/Reletionship (Type, Print)

Green

Frances 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206

Rosetta

4001 Eierman Avenue Baltimore, Maryland 20b. Plece of Disposition (Neme of cemetery, crematory or other place)

20c. Location - City or Town, Stata Dete

1 XBuriel 2 Cremetion 3 Removel from State Voshell Mem. Gardens 08-12-99 Dundalk, MD

22. Name and Address of Facility Baltimore, Maryland 21202

18. Mother's Neme (First, Middle, Maiden Surname)

21. Signeture of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line.

4 ☐ Donetion 5 ☐ Other (Specify)

WM.C.March FH 1101 E. North Avenue

Approximete Interval Between Onset and Deeth

Physician /Medical Examiner

physician and the burial-transit

signed t

peeu

Records, P.O. Box 68760

Division of Vitai

Hospital or Attending P
 24 hours after death.
 Funeral Director: After t

To the Hospital or Atterview within 24 hours after dea To the Funeral Director completely filled in by the

After

Immediate Cause (Finel diseese or condition resulting in deeth)

SEPSIS

Due to (or as a consequence of):

Due to (or es e consequence of):

Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

TEND STAGE RENAL DISEASE HYPERTENSION

24a. Wes en eutopsy performed?

1 Yes

24b. Were autopsy findings svailable prior to completion of cause of death?

1 Yes 2 No

23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

Hospitel: 1 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

27. Mennes of Deeth 1 Netural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28a. Dete of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury st Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 PNO

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier

no

29c. License number

29d. Dete signed (Month, Day, Year)

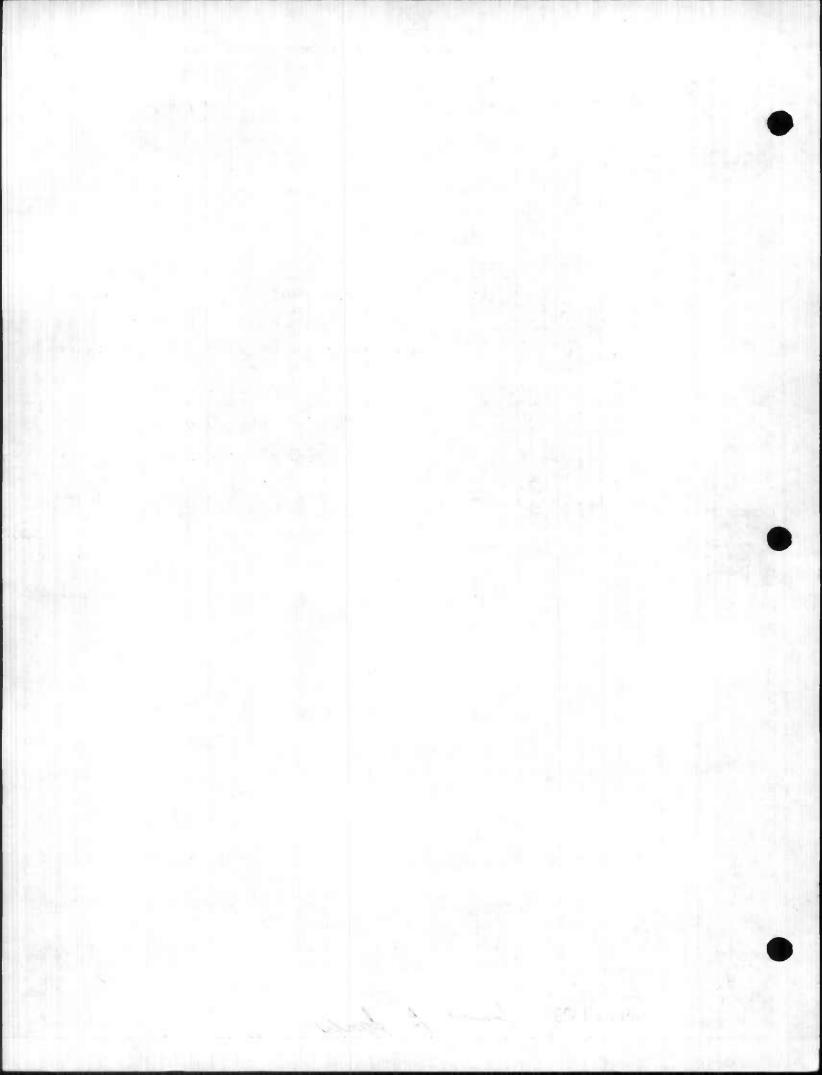
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHUNCH HOSPITAL. BALT. AZEMI.M.D.

Vareni

State Registrar

31. Dete filed (Mortth, Day, Year) AUG 1 1 1999 32 Registrer's Signeture

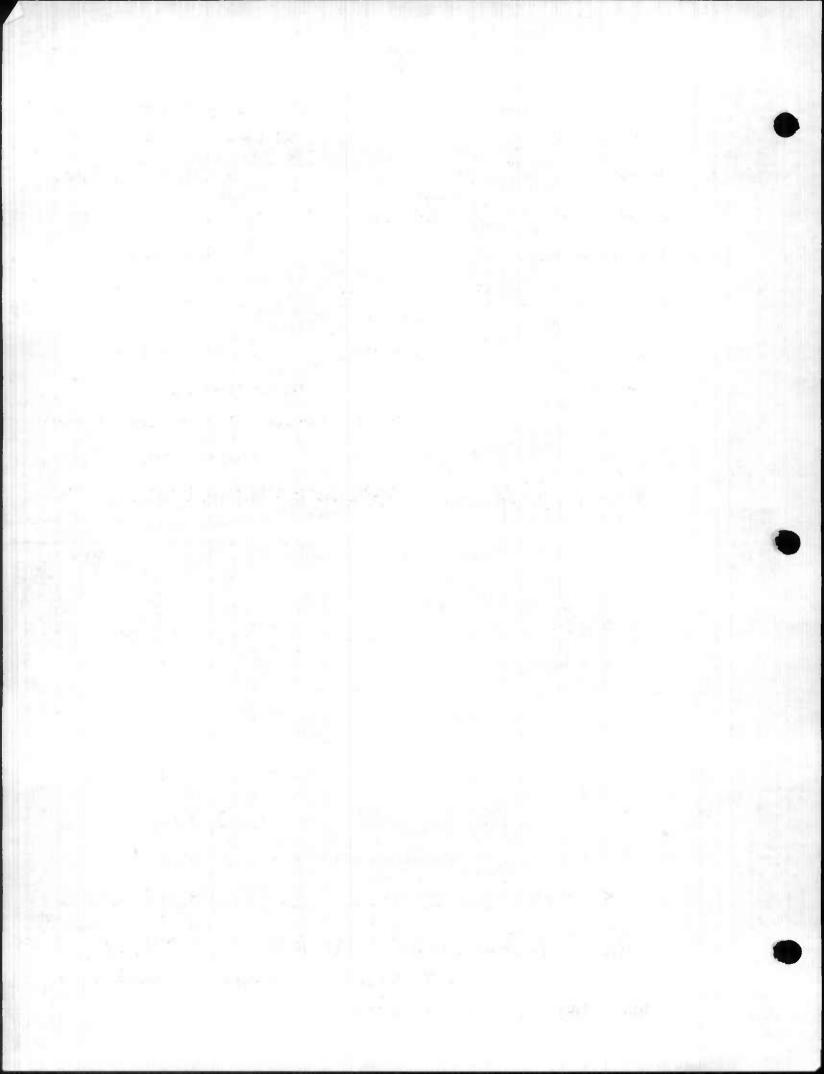


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 5 2 0 2 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Veer 2:30 PM August 5, 1999
cation of Deeth 4c. County of Deeth Nettie M. Fisher /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** 3750 Hickory Avenue Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number **Funeral** Birthplece (Stete or Foreign Country) 1□ M 2XXF Deys Yrs. Director 220-05-5569 78 Sept.24.1920 Maryland Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show e or 28a-f show Maryland N/A Director Yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? death with rn 23e 3750 Hickory Avenue 21211 USA Funeral Herna 2 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. Specify: White r then "natural", or item the Wedital Examiner filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 21215-0020 þ 3 X Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) I Hygiene. Elementery/Secondery (0-12) Cotlege (1-4or 5+) Homemaker Own Home 4 altimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Surneme) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Be Robert Dells Blanche Ethel Young 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sue Fisher 3750 Hickory Avenue Baltimore, Maryland 21211 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stete permit. Page Department of Important: If any Injury or St. Mary's Cemetery 8/9/1999 Baltimore, Maryland 4 ☐ Donetlog 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Neme end Address of Fecility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or high feiture. List only one cause on each line. 21211 Onset end Deeth **Physician** /Medical nmediete Ceuse (Finel CIRNITESIS of 4 RANS disease or condition resulting in deeth) Examiner Due to (or es e consequence ot) Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Box 68760. the Due to (or es e consequence of): P.O. Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 WUnknown Records, þ 24b. Were eutopsy findings avellebte prior to page 2 should Completed 24e. Wes en eutopsy performed? completion of cause 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) this 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Neturel death. 1 Yes 2 No 2 Accident s after death 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) In by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.

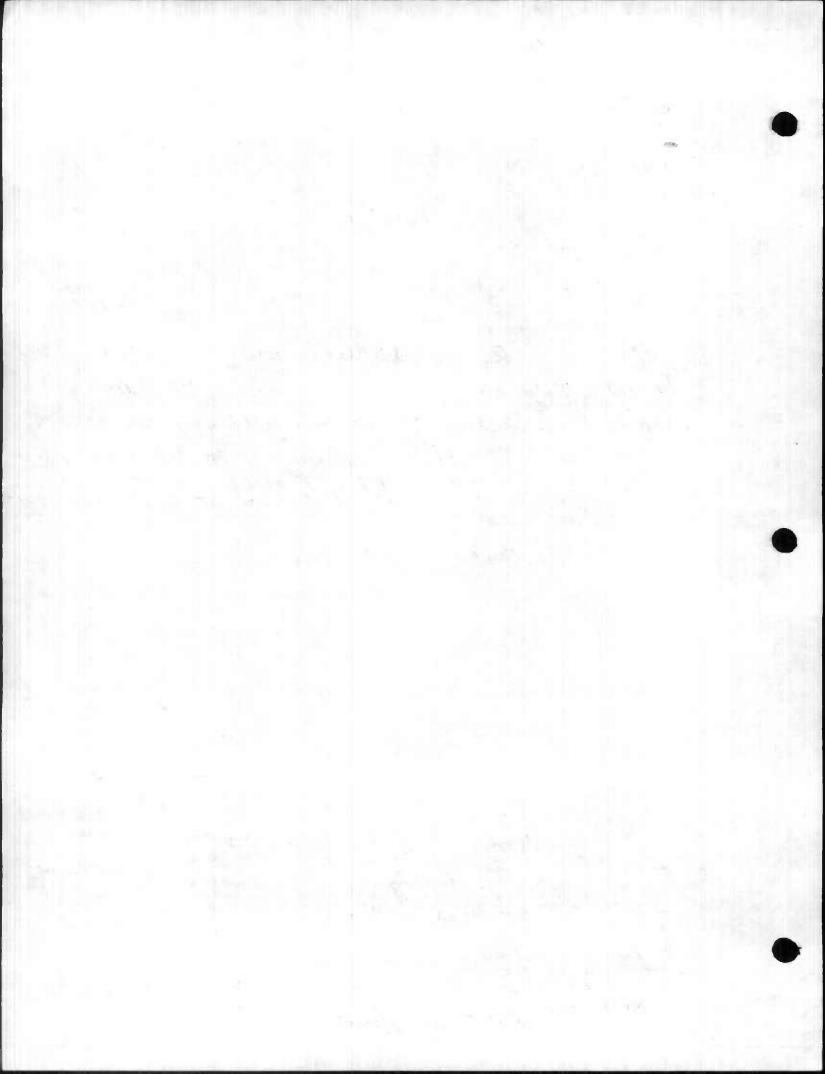
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) end menner stated. Medical 29a. Certifier (Check only one) 29b. Signeture end title of cartitier 29c. License number 29d. Date signed (Month, Dey, Year) 10661 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Mank W. Welliams, 3333 Non Tet Column 57. BALTI mank 32. Registrar's Signatur 31. Dete filed (Month, Dey, Year) State AUG 1 1 1999 Registrar



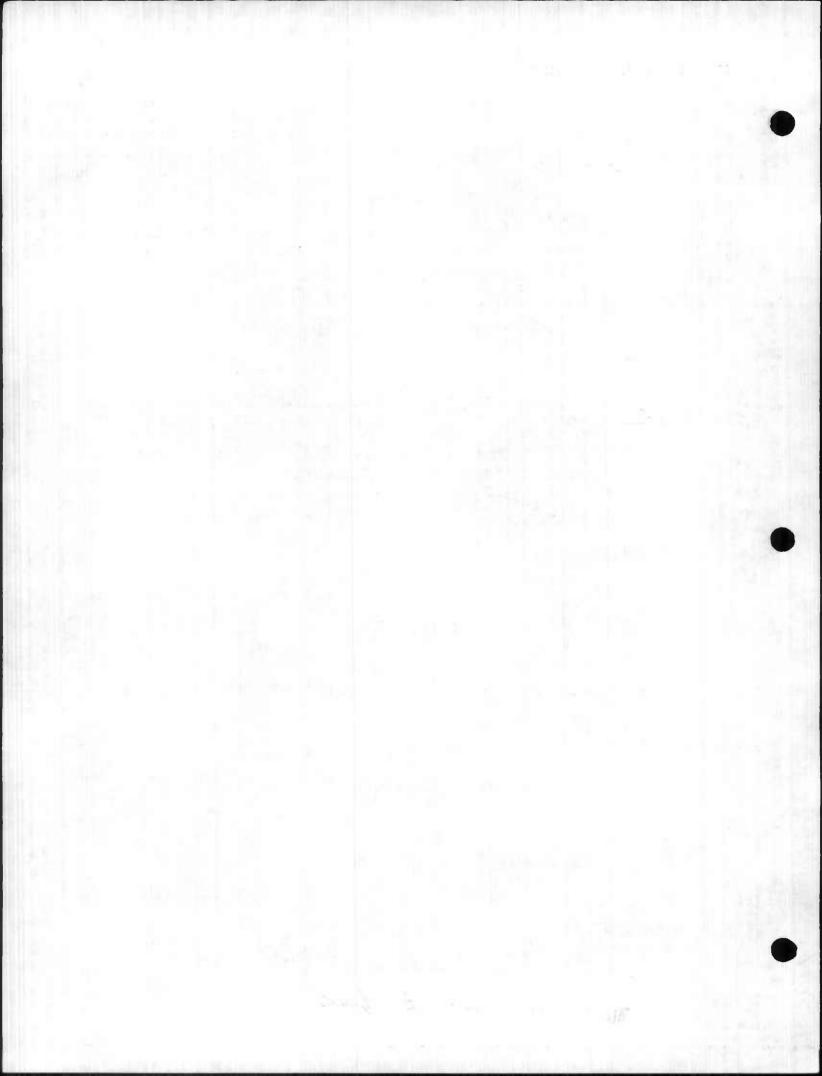
ORIGINAL

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM: #19A PER F.H. G774 8-11-99 WR. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth AUGUST 9, Day 1999 **Physician GOLDMAN** HARRY 10:40 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner REISTERSTOWN BALTIMORE 106 FIRST AVENUE If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In vrs. last birthday) If Under 1 Yeer 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) **Funeral** Days 180 M 2□ F Months 217-20-3952 Director 74 OCT. 18,1924 MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahda anda 1 ☐ Yes 2X No Director BALTIMORE REISTERSTOWN 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 106 FIRST AVENUE 21136 U.S.A. 23a Funeral Items 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. WWII Black, Whita, atc Pages 1 and 2 should be filed within 72 hours after Yes 2 No 1 Never Merried 2 Married Maryland 21215-0020 8 1 ☐ Yes 2 ♥ No Specify: WHITE Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: ARMY natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR SOCIAL SECURITY 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be h and Mental P JOSEPH **GOLDMAN** DORA 19e. Informent's Name/Relationship (Type, Print)
DEMTRA GOLDMAN / WIFE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Nem 27 is 106 FIRST AVENUE - REISTERSTOWN, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State る量る XBurial 2 Cremation 3 Removel from Stete 8/11/99 WOODLAWN, MD BETH TFILOH CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last burial-tran Due to (or es e consequence of): and HAS CUD Box 68760. physician Physician/Medical aug. Due to (or as a consequence of) signed by the atter I be detached for o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 BYS 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to peed completion of cause of death? has this certificate 1 Yes 2 DINO 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Panding investigation To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28a. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner steted. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 104701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3635 OLD COURT ROAD #610 PIKESVILLE, MD 21208 STANFORD MALINOW 31. Dele filed (Month, Dey, Year) 32. Régistrar's Signature AUG 11 Registrar



WRC Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 99-4577-510 State of Maryland / Department of Health and Mental Hygiene NICHELLE M. GODWIN Certificate of Death Reg. No. AMEND #10e&f PER INFMNT G774 8-18-99 J.A 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** Nichelle Godwin AUGUST 05. 1999 5:24 PM. /Medical 4a Facility Nama (ff not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS HOSPITAL BALTIMORE If Undar 24 Hrs. If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 01-16-92 Birthplaca (Stata or Foraign Country) **Funeral** Days Months Min. 1 M 2 Q.F Hours 214-35-5839 07 MD Director Usual Rasidance of Decedant the Marylend 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ehon ehom XX Yas 2 No MD NA Baltimore Director 10e. Street and Number 5509 BOWLEYS LANE 10f. Zip Coda 10g. Citizen of What Country? mas 23a or 3214 Kentucky Avenue 21213 21206 USA Funeral Rems 2 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar In U,S. Armed Forcas? 14. Raca - Amarican Indian. 11. Marital Status Black, Whita, atc r than "natural", or iter tre Medical Examiner filed within 72 hours efter 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Nevar Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yas XXNo Specify: P 3 Wildowed 4 Divorced Black Year or Dates: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Student Student 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Be Pages 1 and 2 should be in nent of Heelth and Mentel I writ: If Item 27 is marked or Donte Godwin Dominique McIntosh 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) 21213 3214 Kentucky Avenue Baltimore, Maryland Sommerville item 27 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata = 8 1 DBurial 2 Cramation 3 Removal from Stata Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore Cemetery 08-12-99 Baltimore, MD 21. Signatura of Funaral Sarvice Licensee Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition rasulting in death) Examiner rowner Due to (or as a consequence ot) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disease or Injury that initiated events rasulting in death) Last and Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco was contributs to the causs of death? detached 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were autopsy tindings svailable prior to complation of cause of death? 24a. Was an autopsy performed? Completed page 2 certificate Division of Vital Attending Physician: funeral director, Be 25. Was casa reterred to medical axaminar? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To XXYas 2□ No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28d. Dascribe how injury occurred \$ ъ 28a. Date of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? 1 Natural 5 Panding mrock, fellants eveck of s efter death. 1 Yes 8 15/99 2 Accidant 3 Suicida invastigation drown 165314R 6 Could not be datamined 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) Herring Rung Park filled in by 4 ☐ Homicida Parkot 6 speek 2200 Cheth Rela Be (timere within 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MacMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edicai 29a. Certiflei completely (Check only onel the 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licansa number O.C.M.E. AUGUST 06, 1999 headone 30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print)

State Registrar

31. Data filed (Month, Day, Year)
AUG 1:1 1999

Registrar's Signatura

9. Apacka

DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201

24 hours after deat Funeral Director:

Medical Certification: To filled in by

Part II. Other significant conditions o	ontributing to death but not resulting In the underlying	23b. Did tobacco use contribute to the cause of did				
			24e. Wes en autopsy performed?	24b. Wera autopsy findings available prior to completion of cause of death?		
25. Was case referred to medical		26. Place of De	eth (Check only one)			
examiner? 1 ☑ Yes 2 ☐ No	Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐	lome 5 Residence 6 □Other (Specify)				
27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	0-7-99	28c. Injury et Work? 1 ☐ Yes 2 ∰(No	28d. Describe how injury occur UNKNOWN	red		
3 ☐ Suicide 6 ☑ Could not be determined	28e. Plece of Injury - At home, ferm, street, fed building, etc. (Specify) RESIDENCE	28f. Location (Street and Number or Rural Route Number, City or Town, State) 4045 COLDSPRING LANE BALTIMORE, MD.				
	yalclan: To the best of my knowledge, deeth occurrations. On the basis of examination and/or investigate					

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 07, 1999

State Registrar 31. Date filed

29b. Signature and title of certifier

32. Registrer's Signeture

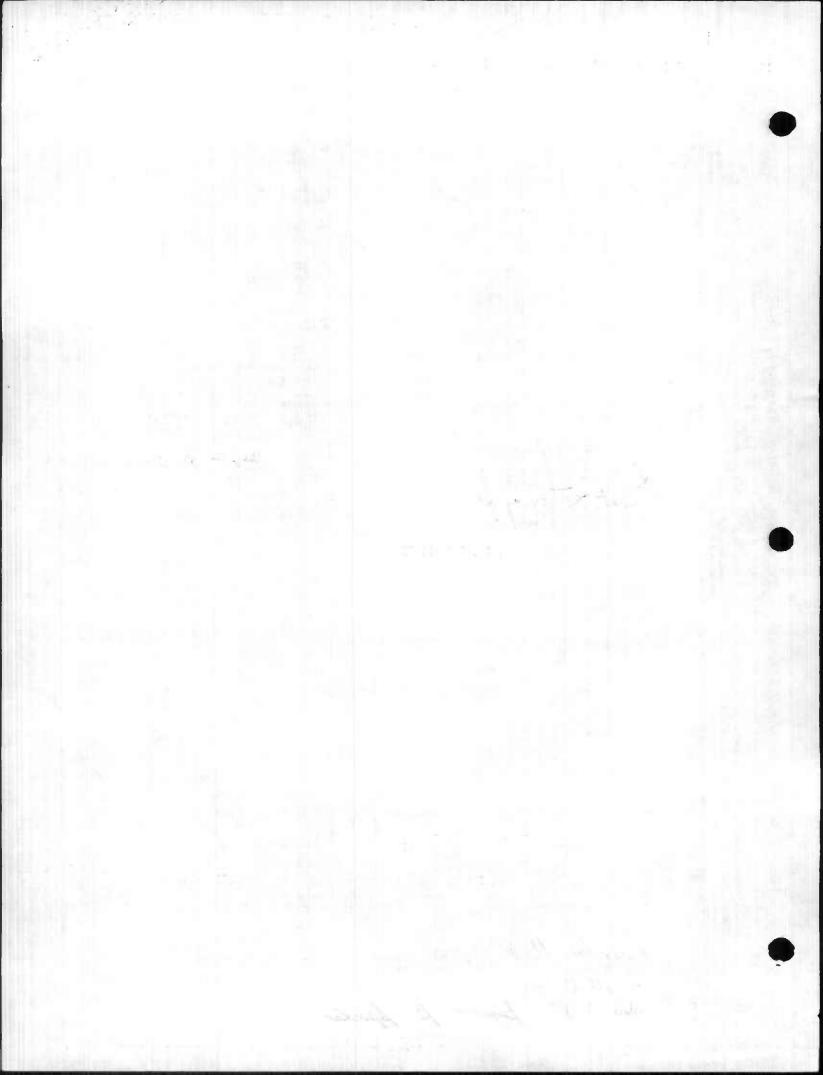
30. Nama end address of person who completed cause of beath (Item 23a) (Type, Print)

ans

111 Penn Street, Baltimore, Maryland 21201

Hospital

within 2



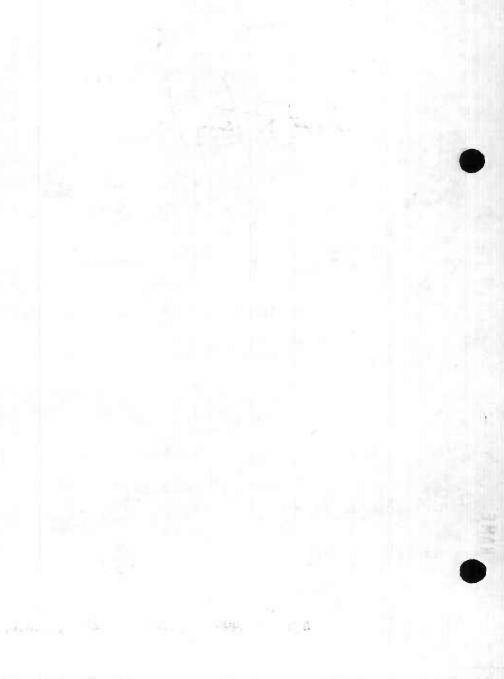
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AU9 **Physician** GASKINS 7:25 pm ILLIAN /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE AGNES HEALTHCARE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2/23/F 97 039-12-8415 Director July 4, 1902 Washington, DC Usual Residence of Decedent 10a Siale 10b. County 10c. City, Town or Location 10d. Inside City Limits show Md. n/a Baltimore Nes 2□No 288-5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 740 Poplar Grove Street 21216 USA 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dales: 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0020 b 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Families 12th Grade Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Pages 1 and 2 should be nent of Health and Mental Francis Brooks Mary Frances Briggs 19a. Informant's Name/Relationship (Type, Print) nephew 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Romeo Gaskins Branson or other th 645 Meadowbrook Avenue Ambler, Pa. 19002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Reproval from State 4 Donation 5 Other (Specify) Aug. 16 Owings Mills, Md. Garrison Forrest Veterans 21. Signature of Funeral Service Licens 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each fine. Onset and Death **Physician** /Medical fmmediate Cause (Final CARDIAL ARREST disease or condition resulting in death) Examiner PULMONARY EDEMA, BRADYCARDIA 24 hrs Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last UROSEPSIS Physician/Medical Due to (or as a cons Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? DEMENTIA þ Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes ZONO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? Attending + Natural 5 Pending investigation s after death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Know, MD P-12704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE STAGNES HEALTHCARE BALTIMORE, MD 21229 AWNA KORRAN

DHMH 16 Rev 6/95

State Registrar

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Gillespie MARCUS August
4b. City, Town, or Location of Death 3:38 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Hospital Northwest Center KANDALL Baltimore STOWN 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Ye ar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Hours Days XXM 2 F Director 238-36-2869 N.C Usuai Rasidence of Decedant the Maryland 10c, City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f sho-1 Yes 25 No Director Baltimore MD Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4500 Chaucer Way Unit 204 21117 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, etc. 1 Yas 2 No 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 20 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elemantary/Secondary (0-12) Coilege (1-4or 5+) 2+ yrs Manager of Blds & Grouds State of Maryland 12th grade 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Pages 1 and 2 should be in not of Health and Mental merked Christopher Gillespie Jane Esther Best 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21117 Health e Kaye Gillespie-Wife 4500 Chaucer Way Unit 204, Owings Mills, Md other important: If item any injury or othe 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from Stata Department 4 ☐ Donation 5 ☐ Othar (Specify) Metro Cremantory Inc 8/11/99 Baltimore, Md 21. Signatura of Funaral Sarvice Licensae 22. Nama and Address of Facility March F/H West 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina. Baltimore Md 21215 Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting In death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial Box 68760. Physician/Medical 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Onknown 1 Yes 2 No Records, þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 100 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 PER/Outpatient 3□ DOA this funaral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Affer 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be datamined 3 ☐ Suicida Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 | Homicida Hospital 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier edical completely (Check only one) Within 2 2 29b. Signatura and Iitla of certifian 29c. License number 29d. Data signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Northwast 32. Registrar's Signature State Registrar

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	8	Funeral Director		5. Social Security Number 6. So	ex 7. Ag	ge (In yrs.		onths	Days Hours Min.	Month, D	ay, Year)	9. Birthplace (State or Fore Country) MARULAND	eign
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	020	ors at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10	Yes 2	A No Specify:		Specify	Black	
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11				resulting in death)			as a consequer	ce of):					
F ST	_	nsit is	Examiner		b. ————			700					
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(C) [Hospi 4 hours Funer tely fil	edical	(Check on) 2 Medical Exam	mer: On the basis o	f examina	wledge, death oc	curred a	it the time, date and place in my opinion, death occi	, and due to the	cause(s) and ma	nner as stated. and due to the cause(s)	
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29b. Signatura and title of certifier	and manner st	ated.		,	License number			d (Month, Day, Year)	
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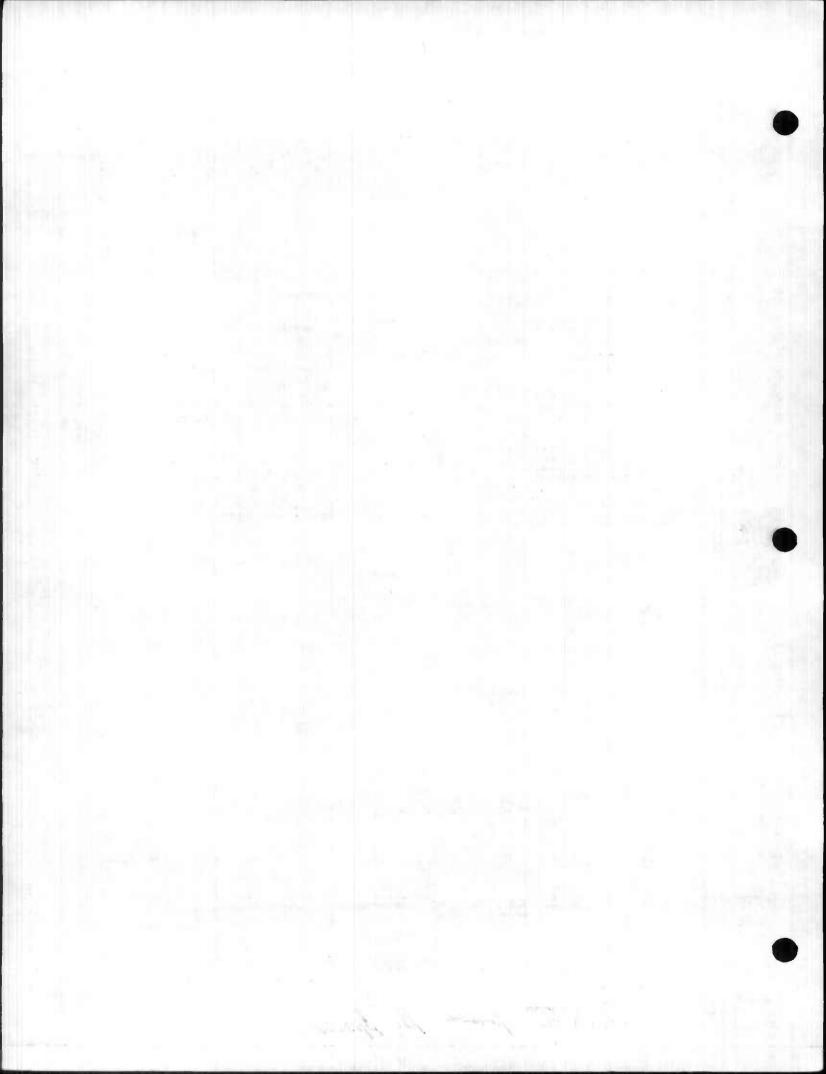
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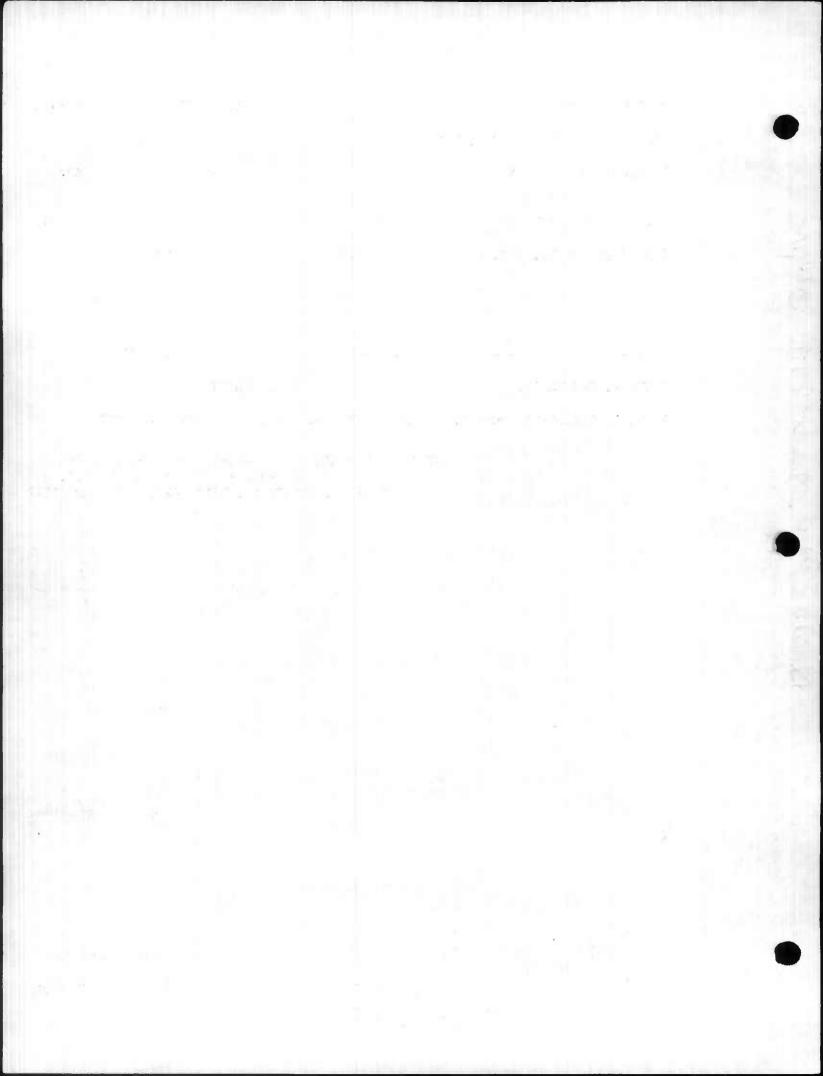
State of Maryland / Department of Health and Mental Hygiene

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erthi	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Tin	na of 28c. In		28d. Describe t				
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To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification		reician: To the best of m iner: On the basis of au and manner stated	amination and/							
within To the comple	29b. Signature and title of certifier	5h-V-	-	29c. Lice	onse number	38	29d. Data signe	d (Month,	Day, Year) 999.	
MI	30. Name and address of person who of JAVAID M	opposed cause of death	n (Item 23a) (T	/pe, Print) 2 300 G			d B	24	MD 21216	
State	31. Data filed (Month, Day, Year)	32. Registrar's				, ,			,	
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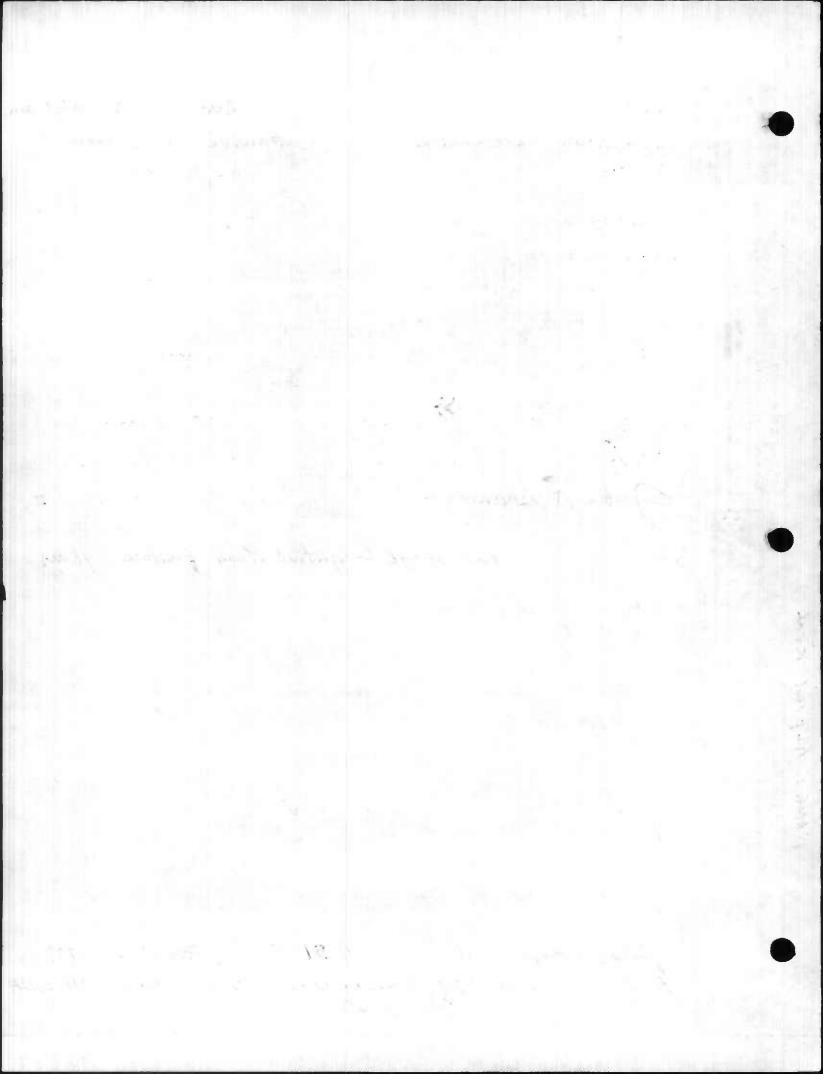
State of Maryland / Department of Health and Mental Hygiene

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Physician		Decedent's Name (First, Middle, Last)			2. Date of De	eth	Yaar	3. Time of Deeth
/Medica	al	DOROTHY C. JONES				7, 199		3:20pm
Examine	r	Ae. Fecility Name (If not institution, give street and number) GILCREST NURSING CENTER (HOSPICE)	4	b. City, Town, or Lo TOWSON	ocation of Deeth		of Deeth	RE
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un Monti	der 1 Yeer hs Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De 12-9-	22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	9. Birthp Cour	place (State or Foreign MD .
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/ and share	0	19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addr		and Number or Run	el Route Numb			
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06		30. Name and eddress of persop who completed cause of death (Month, Dey, Yeer) 31. Date filled (Month, Dey, Yeer) 32. Registrer's Stonature	16-0	Charles	St. 1	Balto	. me	1999
State Registrar	7	31. Date filled (Month, Dey, Yeer) ALIG 1 1 1999	11					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 9 9 2 5 2 1 2

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	17. Fa	her'a Nama	(First, Mid	dla, Last)							18. Moth	er's Nama	(First, Middl	e, Maiden Sun	mama)		
	Fra	nk Kra	11								Mary	Sad1	ek				
	19a. li	lomant's N	ame/Relati	ionship (7	Type, Print))		19b. Meilin	ng Addre	ss (Street a	and Numb	er or Rura	Routa Num	ber, City or To	wn, State	, Zip Code,	212
	Ime	lda E.	Kra.	1 / V	Vife						ice I	Lane,	CC 41	3, Cat	onsv	ille,	Md
	11	athod of Dis Burial 2 Donation	☐ Cremali			rom State		Place of Dispo cematery, cren dar Hi	matory or	other place		8	Data / Q / Q Q	Brook			
SOUCE	21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, 23a. Part/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	1	Ja	clei	A.	SI	hat caused on aach lin	tha deat	4	107	Wilke:	ns Av	renue	, Balt	imore,	Mary	Appro	oximale rei Between
liner	23a. F	Ja	the disease of failure.	o, or comp List only o	olications the			h. Do not ente	107 ter the mo	Wilke	ns Av g, such es	zenue cardiac o	, Balt respiratory	imore,		Appro Interv Onse	oximale rel Between I and Death
Medical	23a. F	arty Entar t hock, or hea	he disease in failure. I (Finel anditions, inmediale orlying injury	o, or comp List only o	olications the	Eus	Dua to (c	h. Do not ente	107 Iter the mo	Wilke: ode of dying Ong a	ns Av g, such es	zenue cardiac o	, Balt respiratory	imore,		Appro Interv Onse	oximale rel Between I and Death
Medical	23a. F tmmeddiseas rasulti Seque if any, cause that in rasulti	rent/ Enter thook, or headilate Cause e or conditioning in death) Initially list colleading to in Enter Under Und	he disease in failure. I (Finel anditions, a	a, or complication of the control of	b	En	Dua to (c	th. Do not enter Trail or as a consequence as a consequ	ter the model of t	Wilke: One of dying One of dying One of dying One of dying	ns Av	e H	eat	fail	lule	Approximately Onse	oximale nel Between I and Death
r ilyaiciai vinedicai	23a. F tmmeddiseas rasulti Seque if any, cause that in rasulti	rent/ Enter thook, or headilate Cause e or conditioning in death) Initially list colleading to in Enter Under Und	he disease in failure. I (Finel anditions, a	a, or complication of the control of	b	En	Dua to (c	f. Do not enter	ter the model of t	Wilke: One of dying One of dying One of dying One of dying	ns Av	e H	eaf	imore,	contribu	Approximate to the c	eximale cell Between I and Death
of injectationical	23a. F tmmeddiseas rasulti Seque if any, cause that in rasulti	rent/ Enter thook, or headilate Cause e or conditioning in death) Initially list colleading to in Enter Under Und	he disease in failure. I (Finel anditions, a	a, or complication of the control of	b	En	Dua to (c	th. Do not enter Trail or as a consequence as a consequ	ter the model of t	Wilke: One of dying One of dying One of dying One of dying	ns Av	e H	eaf 23b. Dic	fail	contribu	Appropriate to the control of the co	euse of de Unkultopsy lindingprior to
of injectationical	23a. F tmmeddiseas rasulti Seque if any, cause that in rasulti	rent/ Enter thook, or headilate Cause e or conditioning in death) Initially list colleading to in Enter Under Und	he disease in failure. I (Finel anditions, a	a, or complication of the control of	b	En	Dua to (c	th. Do not enter Trail or as a consequence as a consequ	ter the model of t	Wilke: One of dying One of dying One of dying One of dying	ns Av	e H	eaf 23b. Dic 10 24a. Wa	fail tobecco use Yes 200	contribu	Appropriate to the competition of the competition o	euse of de Unku
Completed by higherinal medical	23a. Fs tmmeddiseas rasulti Seque if any, cause Cause that in rasulti Part tt.	rent/ Enter thook, or head iteles are conditioning in death) Initially list colleading to in Enter Under	he disease in failure. If	ditions co	b c	En	Dua to (c	th. Do not enter Trail or as a consequence as a consequ	ter the model of t	Wilke: ode of dying PNS S.): cause give	ns Av	e H	eaf 23b. Dic 10 24a. Wa	tobecco use I tobecco use Yes 2004 S an autopsy formed?	contribu	Appropriate to the completion of death?	euse of de 4 Unkutopsy linding prior to on of cause
to be completed by Physician/Medical	23a. Fs tmmerdiseas rasulti Seque if any, cause Cause that in rasulti Part tl.	rant/ Entar thook, or head itself cause e or conditioning in death) intiatly list colleading to in Enter Under (Disease or tiated eventing in death).	he disease in failure. If	ditions co	b d	Euc	Dua to (co	th. Do not enter as a consequence as a c	107 ter the mo	Wilke ode of dying and a cause give	ns Av g, such es f LV en in Part	e of Death	23b. Dic 1 24a. Wa peri	dimore, arrest, fa: fa: fa: fa: fa: fa: fa: fa	contribute 3 24b	Appropriate to the competition death?	euse of de 4 Unkutopsy linding prior to
floation: To Be Completed by Physician/Medical Examiner	23a. Fs tmmeddiseas rasulti Seque if any, cause Cause that in rasulti 25. Wa axt	rant/ Entar thook, or head itself cause e or conditioning in death) intially list colleading to in Enter Under (Disease or tiated eventing in death). Other significance of the collean individual in	he disease in failure. If	dical did not be	b b c hontributing the properties of the pro	Euro	Dua to (co	th. Do not enter the property of as a consequence of a consequen	107 Iter the mo	Wilke: ode of dying Physical Scause gives Cause gives OOA Other 28c. Injury Work 1 Y	ns Av g, such es f LV en in Part	e of Death No	23b. Dic 1 24a. Wa per 1 (Check only na 5 Res 8d. Describe	d tobacco use I tobacco use I yes 2000 S an autopsy formed? I yas 2000 One) Sidence 6 0 0 how injury oc	contribution 3 Discourred	Appropriate to the completion of death? 1	euse of de deprior to on of cause
o Be Completed by Physician/Medical	23a. Fs tmmed diseas rasulti Seque if any, cause Cause that in rasulti Part tl. 25. Wa axi 1 [27. Ma 1 [3 2 2 3 2 4 2 3 2 3	renty Enter thook, or head itself cause e or conditioning in death) intiatly list colleading to in Enter Under (Disease or tiated eventing in death). Other significant of Deat Matural Accident I Suicide I Homicida	he disease in failure. (Finel on mediale shying injury shart concerning to mediale shying injury shart concerning the mediale shart concerning the	dittions co	b b c d Hospitel: 1 28a. D	Euro to death be late of Injuiding, etc.	Dua to (co	th. Do not enter the property of as a consequence of a con	107 Iter the mo	Wilke: ode of dying OA Othe 28c. Injury Work Dry, office	26. Place 26. Place 27. 4 D No. 28. 2 D	e of Death No 2	23b. Dice 1 Check only or To the due to the due to the	dimore, arrest, fa: fa: fa: fa: fa: fa: fa: fa	contribution 3 24b	Appropriate to the competition of death? Rural Route as stated, use to the competition of death?	ause of da 4 Unk Lopsy linding to on of cause 210 No a Number, ause(s)



Loughrey

7. Age (In yrs. last birthday)

38

10c. City, Town or Location

Baltimore

99-4619-510

If Under 1 Yeer

10f. Zip Code

Months

Deys

State of Maryland	/ Department of Health and	Mental Hygiene
	Certificate of Death	Pag Ma 9 9

2. Dete of Death

8,

1999

4c. County of Deeth

10g. Citizen of What Country?

Month

AUGUST

111 Penn Street, Baltimore, Maryland 21201

4b. City, Town, or Location of Death

H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

BALTIMORE

3. Time of Deeth

8:05P.M.

Birthplece (State or Foreign Country)

10d. Inside City Limits

Approximate tritarvel Between Onset and Deeth

24b. Ware autopsy findings available prior to completion of cause of death?

1 Yes 2□ No

1 Yes 2 No

Maryland

White

Physician
/Medical
Evaminer

1. Decedent's Neme (First, Middle, Last)

4a Facility Neme (If not institution, give street and number)

10b. County

Geraldine

5. Social Security Number

212-84-7121

10e. Street and Number

10a. Stete

Usual Residence of Decedent

F.

1 M 2 F

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

6. Sex

Funeral Director

the Mandand show "natural", or itema 23a or 28a-f shored sales in a notified at filed within 72 hours after death

ith and Mental Hygiene. 27 Is marked other than "r r treumatic event, p. Med Pages 1 and 2 should be 1 nent of Health and Mental I int: If item 27 is marked of fitem 2. 主 Department of Important: If any Injury or

21215-0020

Baltimore, Maryland

Box 68760

of Vital Records, P.O.

Division

Physician /Medical **Examiner**

The law requires that the death certificate be assecuted burial-tran the r use as t this certificate has Physician: funeral After or Attending To the Hospital ... within 24 hours after death.
To the Funeral Director: A death.

Director 3301 E.Northern Pkwy. 1st Floor 21206 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 ☐ Never Merried 2 🂢 Merried 1 ☐ Yes 2 No Specify: ò Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Cafeteria Helper Food Service 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Eugene Ruby Lorraine D. Blackwell 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey C. Loughrey -Husband 3301 Northern Pkwy. 1st Floor, Baltimore, Md. 21206 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 D Burial 2 □ Cremation 3 □ Removal from Stete 8/12/99 Owens Mills, Md. Garrison Forest Veterans 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Leonard J.Ruck Funeral Home 21. Signature of Funerel Service Licenses 5305 Harford Rd.Baltimore, Md. 21214 Deovanne Dari 23a Part Length disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hand feilure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown á Completed 24e. Wes en autopsy parlormed? 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To Yes 2□ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred.

Driver of venicle loses 27. Menner of Death 28b. Time of 28c. Injury at Work? Contro Centrol Striking fixed exect and cratura 281. Location (Street and Number or Aural Adule Number, City or Topm, State) 1 Naturet 5 Pending investigation Place of Injury At home, ferm, street, fectory, office building, etc. (Specify) 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 7 9 timore Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the (Check only one) ner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E. AUGUST 9, 1999

State Registrar

DHMH 16 Ray 6/95

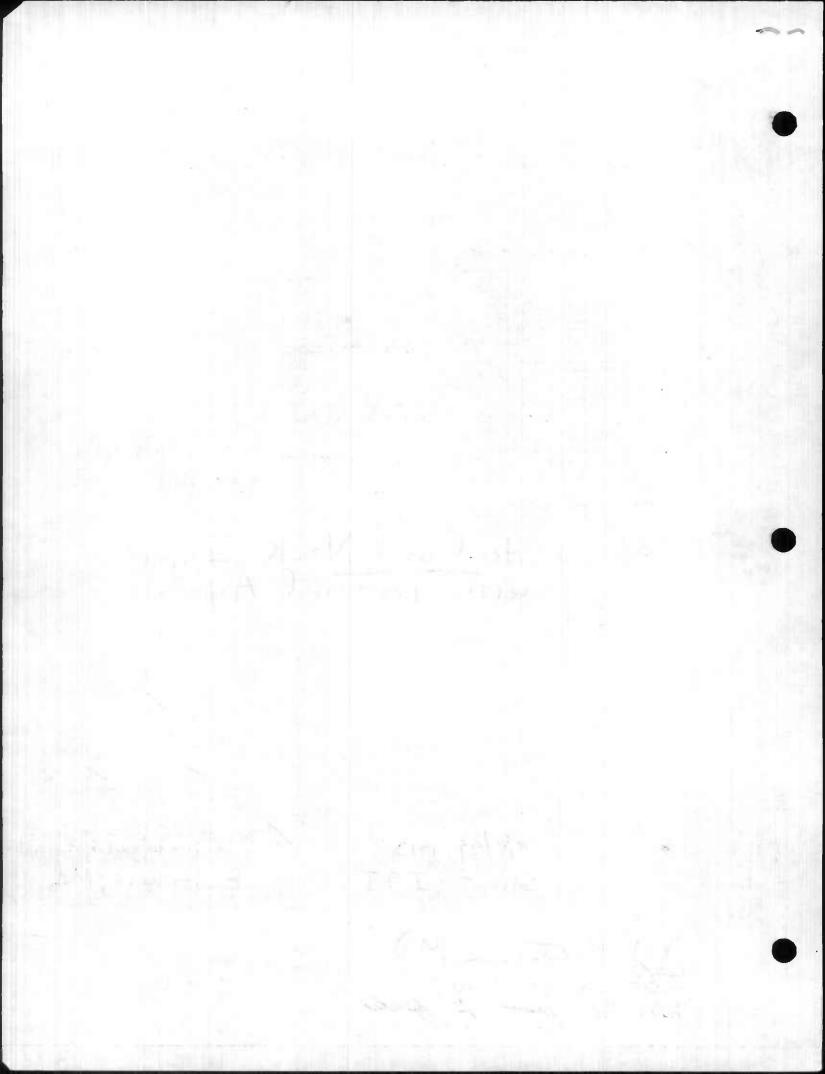
diress of person who completed cause of death (Item 23a) (Type, Print)

32, Pagistrar's

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G I I 1999



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Month **Physician** 5, Heung Jae Lee AUGUST 1999 1634 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WELLHAM AVE. GLEN BURNIE Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In vrs. last birthdey) Birthplaca (Steta or Foreign Country) **Funeral** Months 1₩ 2□ F 213-94-5439 72 Director S. Korea Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b County 10d. Inside City Limits 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie Director 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 6909 Glen Ridge 21061 USA Funeral 12. Was Decedant Ever In U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No 1 ☐ Nevar Married 2 ☑ Married Saltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: Specify: py Korean 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 'nethursi'. Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Janitor (Maintenance) Truckina 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Yak Han Lee Young Pyoung Hong 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) if them 27 is or other train Young Son Lee - wife 6909 Glen Ridge, Glen Burnie, Md. 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c, Location - City or Town, Stata 8/09/99 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If Elkridge, Md. Meadowridge Mem. Park 22. Nama and Address of Facility 21. Signature of Funeral Service Lion Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 23a. Pure Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner ue to (as a consequence of): Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): 88 for use 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate has 2□ No or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only ona) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1X Yes 2 No this SCENE funeral 28b. Time of Injury 27, Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Affert 5 Pending Investigation Division subject hoged off 1 Netural Forward 8/5/99 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 1620 HRM 2 Accident 3 Ouicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide extlike wooded area 5.25 Wellbean Attance Then Burnie Maryland Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.

Commedical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

completely X State Registrar

THEODORE MIKENS 31. Data filed (Month, Dey, Year) AUG 11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signatura and titla of certifian

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

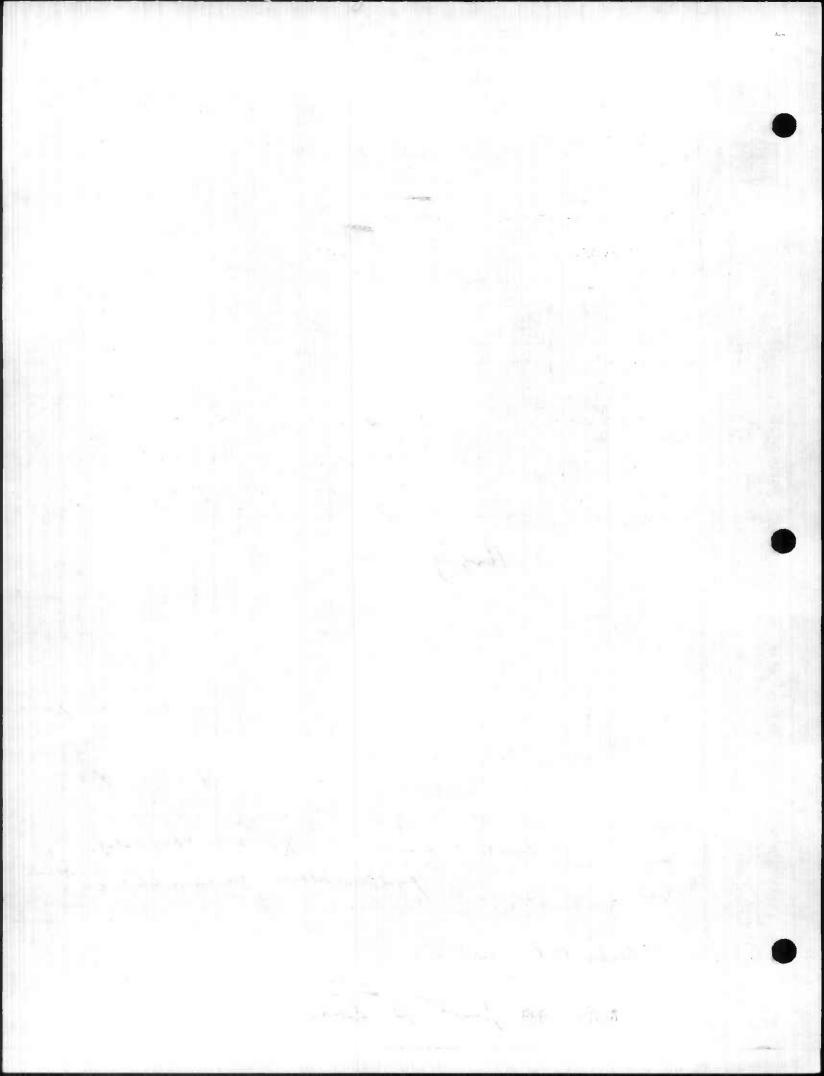
29c. Licansa number

O.C.M.E.

29d. Data signed (Month, Day, Year)

AUGUST 06, 1999

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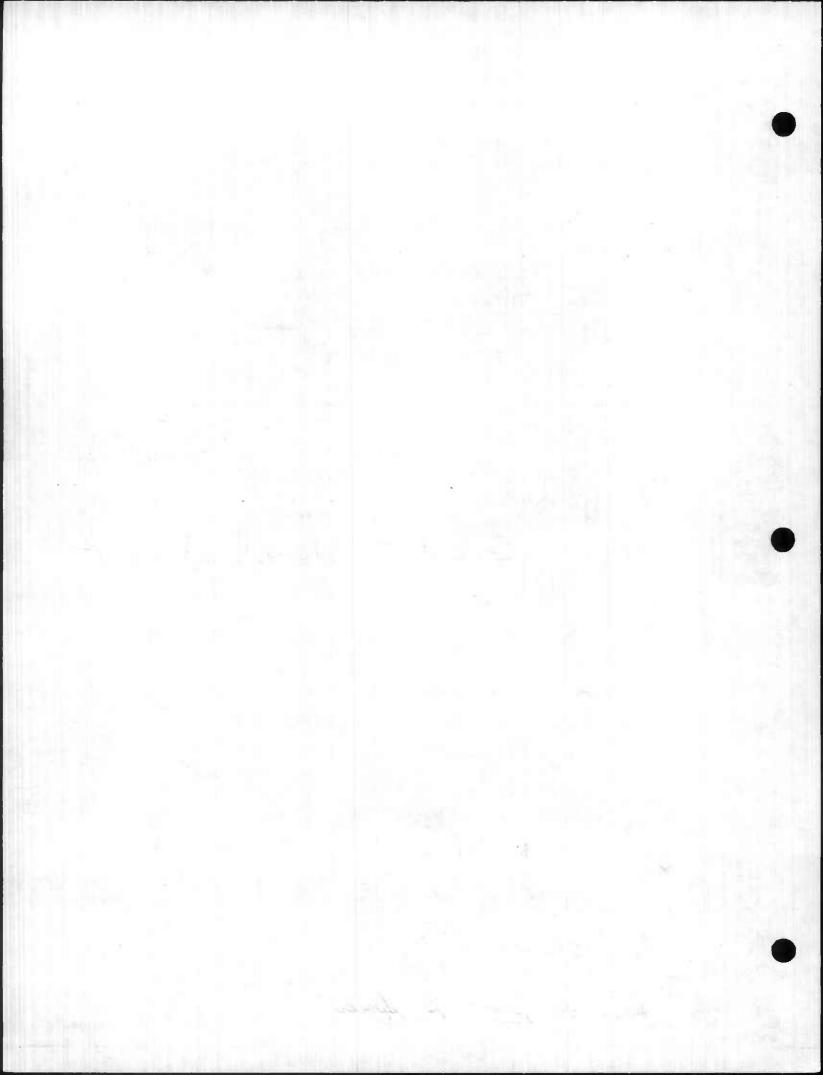


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 3. Tima of Death **Physician** TRAVIS LOYAL 08 1999 04:31 PM. August /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days 10 M 20 F 216-98-7117 18 Yrs MD. **Director** Usual Rasidence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show 1 ☐ Yes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? re 23e or 519 N. STREEPER ST. 21205 USA Funeral death r than "netural", or heme Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11. Marifal Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give A 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK py 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

16a. Do NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STUDENT N/A 7 is marked other traumatic event. Baltimore, Maryland 17, Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Pages 1 and 2 should be fit tment of Health and Mental H tant: If them 27 is marked off JOSEPH LOYAL JEQUIDA BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEQUIDA BELL (MOTHER) 519 N. STREEPER ST. BALTIMORE, MARYLAND 21205 20b. Place of Disposition (Name of cematery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State NSBurial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8 permit. Page Department of Important: If any Injury or 8-13-99 BALTIMORE, MARYLAND ZION CEMETERY 22. Name end Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens tor 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** ound of Chest tmmediete Ceuse (Finet disaase or condition resulting in death) Examiner Due to (or as a consequence of) Sequantially list conditions, if any, teading to immediata ceuse. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Physician/Medical Due to (or as a consequance of) Part tt. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. à 1 Yes 2 No 3 Probably 4 Unknown þ 8 24b. Were autopsy findings aveilable prior to completion of causa of death? Be Completed 24e. Was an autopsy performed? 1 PYes 2 No 1 Yes 2 No certificate Division of Vital 25. Was cese referred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Medical Certification: To 1X Yas 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ä 28a. Date of Injury (Month, Pay Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affisi 1 Netural 5 Pending 624 Sinb no 1 Yes 2 No invasfigetion 20 2 Accident after death Director: 6 Could not be determined 3 Sulcida Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, Sity or Town, State) 4 Homicide Bidd BaltimoreMo Block e No the Hospital
within 24 hours a
To the Funeral E
completely filled OT 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29b. Signature and titlerof certifier 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E. August 09, 1999 completed ceuse of death (Item 23a) (Type, Print) tane T11 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month) 32. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene

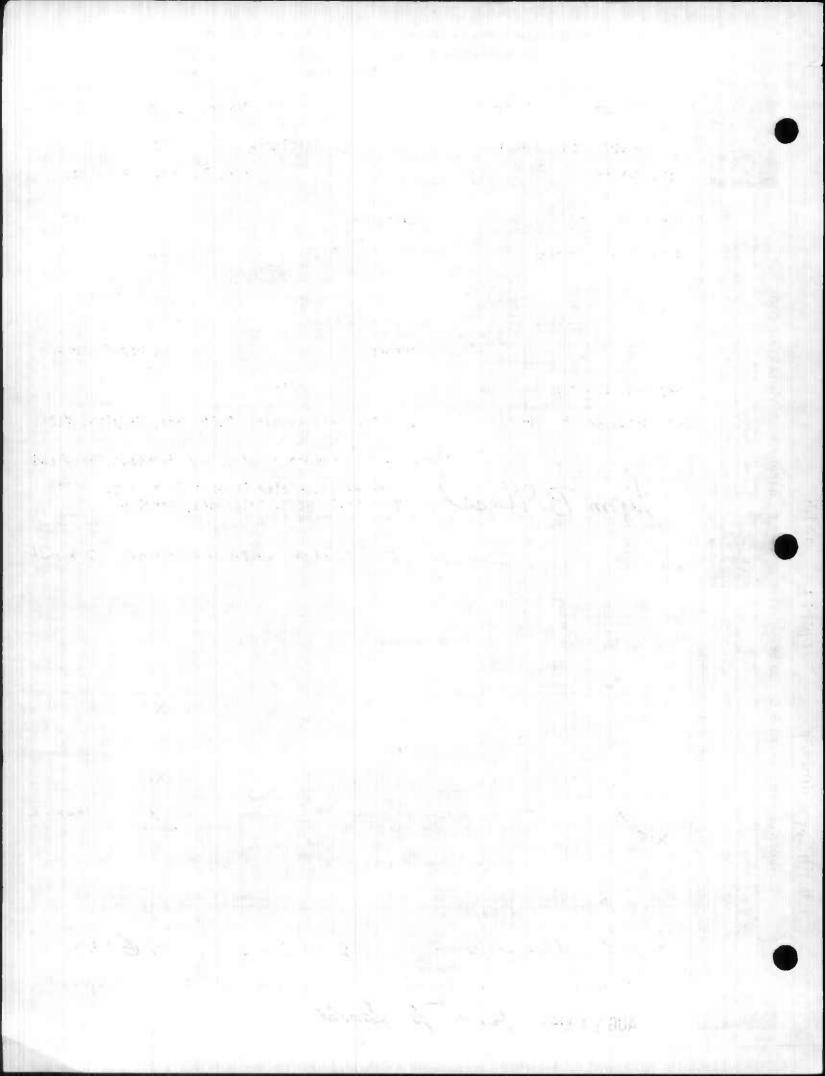
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 Month 630PM **Physician** August 5, William Η. Lambert · /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice
5. Social Security Number 6. Sex 7. Baltimore If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Hours 10 M 2□ F Months Days 82 Yrs. Feb. 7, 1917 Director 215-07-6466 Maryland Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner main be notified at XYes 2□ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Roland Avenue 21211 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23, any injury or other traumatic event, or healt 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: Specify: White p 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Foreman Tire Manufacturing 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Haywood Lambert Elsie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) Constance Groft Daughter 1416 Medfield Avenue, Baltimore, Maryland 21211 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 8/10/1999 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. A Funeral Service Licenses 21211 3631 Falls Road, Baltimore, Maryland in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, earl failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Colon with medastasis Cancer Examiner Due to (or as a consequence of) Examiner physicien end the burial-transil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): USe 23b. Did tobacco use contributa to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hespie 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dorl CAL D14383 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Richey Hospice Stand: ferd 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 1 1999

DHMH 16 Rev 6/95

MIDSON

William Lambert



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene David Michael Lates UNKNOWN (99-177 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year **Physician** Michael Lates 1999 AUG. 4:34 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4500 FAIRFAX ROAD BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 11XM 2□ F 20 Yrs Director 219-94-5276 March 4, 1979 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD Baltimore Middle River or 28s-f 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Norms 23a 706 Grantwood Rd 21220 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1⊠ Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: altimore, Maryland 21215-0020 b 1 ☐ Yes 21 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Installer Carpet 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Joseph D. Elrod 0 Debra Lates 19a. Informani's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Department of Health, Important: If Item 27 Is any injury or other tra 710 Lilly Pond Ct. Joseph Jenkins /uncle Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 図 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 11 4 ☐ Donation 5 ☐ Other (Specify) 1999 Holly Hill Memorial Middle River, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Connelly Funeral Home of Dundalk onn 7110 Sollers Point Rd 21222 23a. Part1. Enter the diseating or complications that ceused the distribution of the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Junglet Wounds /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be assecuted and Sequentially list conditions, it any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown ata has been signed by page 2 should be detac 1 Yes 2 No 3 Probably Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No Yes 2 No certificata Vital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XX ther (Specify) AT SCENE Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Yes 2□ No edical Certification: To of this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Division 1 Natural Injury 5 Pending Subject Shot investigation 1 Yes within 24 hours after death. To the Funeral Director: A Found 8/7/99 2 Accident 0320 HRM 6 Could not be determined 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4500 FRIVER RUN Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end manner as stated.

XIX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. completely filled Hospital 29a. Certifier and manner stated. ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar **DHMH 16 Rev 6/95**

Theodore King M.D. 31. Date filled (Month, Day, Year) AUG 1 1 1999

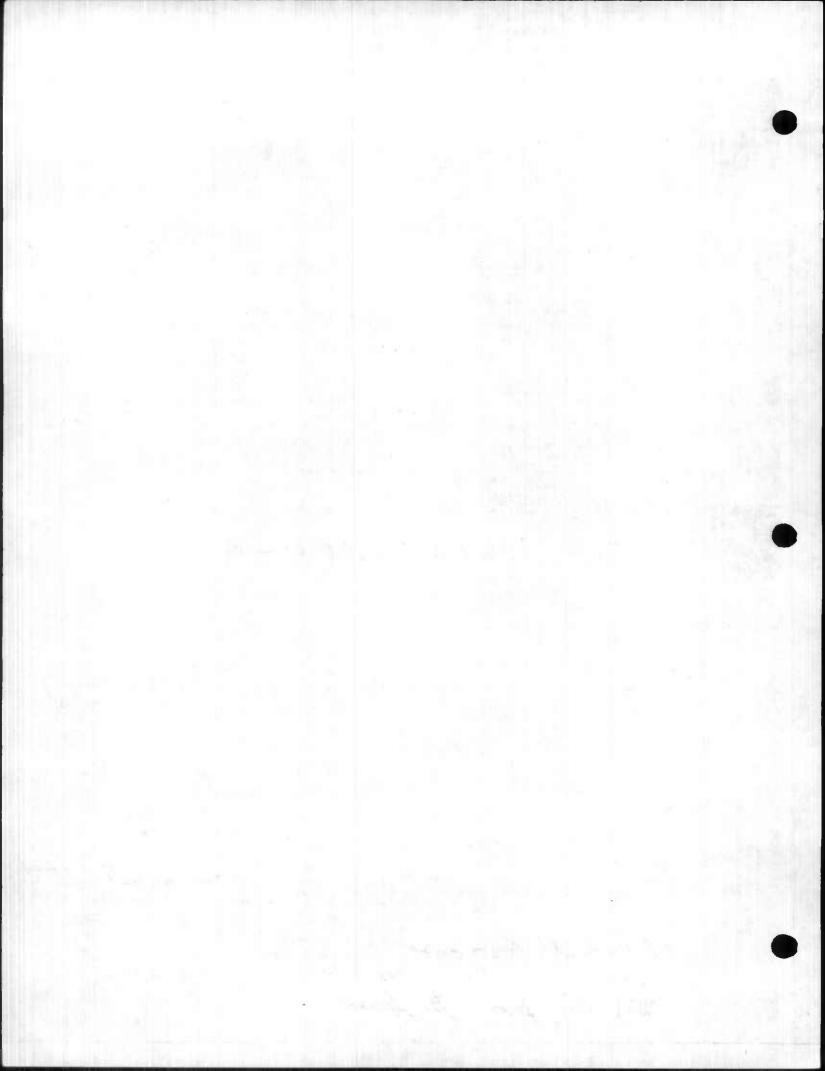
32. Registrar's Signature

30. Name and address of person who completed ceuse of math (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E

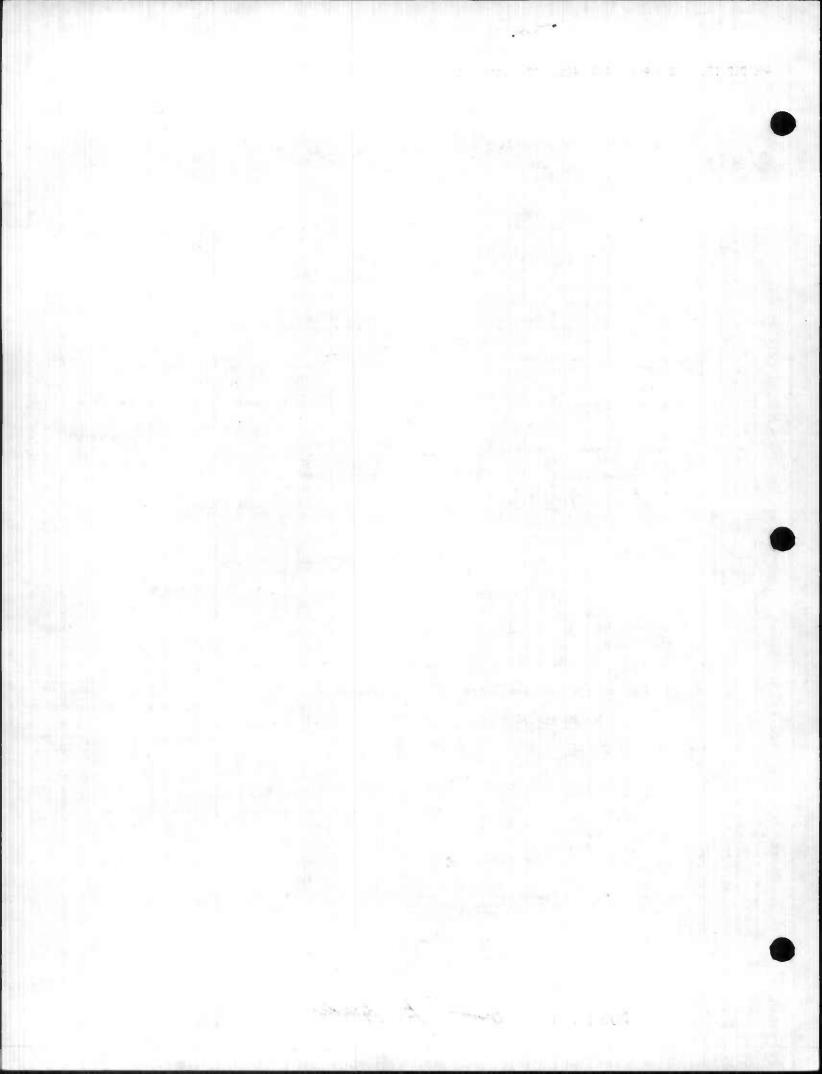
AUG. 7, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene-AMENDED ITEM # 24a PER VERBAL RES. G774 8/11/99 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 240C PROT /Medical 4e Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner SAHIMORE 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10M 20 F Months Days 45 Yrs. Director 214-64-8418 NOV 30,1953 BALTIMORE, Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director 28a-f MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð Berns 23s 2901 WALBROOK AVE. 21216 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Merried 2 ☐ Married 'natural', or Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify Specify: AFRO.AMERICAN þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) HECHANICAL MACHANICAL AUTO marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental DAVID MOSLEY ETHEL MOSLEY 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other tra ORGS. Health GWENDOLYN 921 KYNDHURST STREET, BALTIMORE, MARYLAND 21229 MACK SISTER 20e. Method ot Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 ☐ Other (Specify) WESTERN STAR CEMETERY 8/13/99 CATONSVILE, MD. 22. Name and Address of Facility
ESTEP BROTHERS FUNERALSER, P. A.
1300 EUTAW PLACE, BALTIMORE, ADDRESS OF THE PROPERTY OF T 21. Signature of Funeral Service Licenses LLOYD ESTEP 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert railure. List only one cause of each line. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Neumonia Examiner Examiner ACINOMA physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Box 68760. SIONS EURA Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 88 189 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, à 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 20 No 1 Yes 2 No ecen 25. Was case reterred to medical axaminer? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Division or Attending 1 Natural 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

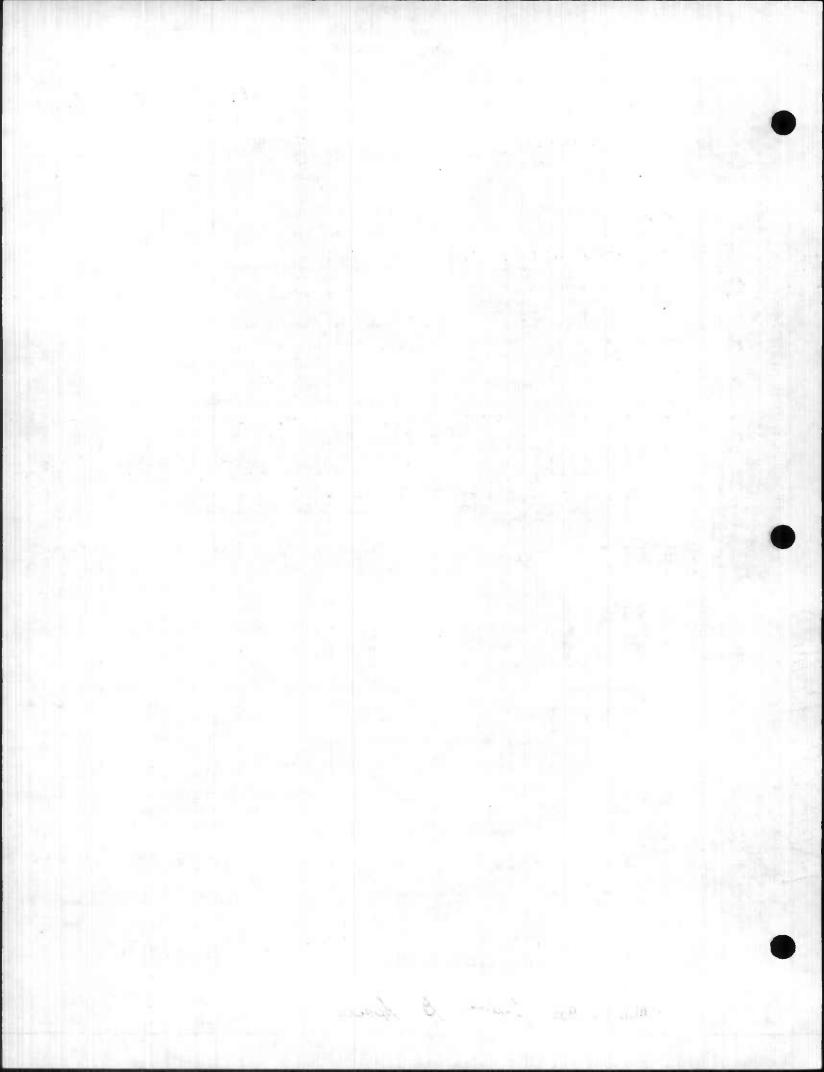
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who compl BAHimore MD21201 22 S. Greenest MARYLAND NIVERSITY 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 1 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 252 | 9

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Physician	Decedent's Name (First, Middle, La					Date of D	path 60 19	3. Time of Death				
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miner	4a Facility Neme (If not institution, give	re street and number)		1	lb. City, Town, o	r Location of	4c. County of	of Deeth /				
	LEVENDALE NURS				BALTI		N/A					
at or		Sex 7. Age (In y		Under 1 Year onths Days	Hours Mi		lay, Year)	Birthplace (State or Foreign Country)				
	217-22-8196		71 '''s.			2-1	2-28	MD.				
	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Locatio	on .				10d. Inside City Limits				
20	MD. N/A		BALTIMORE					1 ☑ Yes 2 ☐ No				
Director	10e. Street and Number											
늄				Of. Zip Code			10g. Citizen of W	nat Country?				
٤	3000 REISTERSTO			2121			USA					
Funeral	11. Marital Status	12. Wes Decedent Ever in Armed Forces?	13. Wes	s, specify Cuba	ispanic Origin? in, Mexican, Pu	(Specify Yes or Norto Rican, etc.)	Bieck	Race - American Indian, Bieck, White, etc.				
by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give	101	Yes 2 No	Specify:		Specify:	BLACK				
	^	Year or Dates:	40 D 4 4		41							
ള	15. Decedent's En (Specify only highest gra	ade completed)	16a. Decedent's (Give kind life. DO N	of work done	ation during most of w	orking	16b. Kind of Bu	siness/industry				
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NT SEAL			GOVER	RNMENT				
	-12- 17. Father's Name (First, Middle, Last,	-0-				ama /First Middl	e, Meiden Surname					
8	BENNY MORSELL			E 171	UNKN		e, Melderi Surrame	9)				
2												
	19a. Informant's Neme/Reletionship (ber, City or Town, :					
	CHARLENE JOHNSO					1	т —	E, MARYLAND 21				
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐	Removal from State	 Plece of Disposition cemetery, cremetor 	n (Name or ry or other plec	ce)	Date	20c. Location - 0	- City or Town, Stete				
	4 □ Donation 5 □ Other (Specif		ETRO CREMA	TORY		8-10-99	BALTIMOF	RE, MARYLAND				
	21. Signature of Funeral Service Licenses 22. Name end Address of Fecility VERNON R. BAILEY FÜNERAL SERV											
	1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217											
		plications thet caused the de	eath. Do not enter the	e mode of dyin	g, such es card	ac or respiratory	arrest,	Approximate				
г	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsel and Death											
н	disease or condition resulting in death) a. SQUATIONS LETE LETE LETE ATCHETE											
5		Due to	o (or as a consequenc	oe of):								
Examin	b.											
Exa	Sequentially list conditions, life any, leading to immediate											
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Due to (or es a consequence of): C											
edical	that initiated events resulting in death) Last Due to (or es e consequence of):											
\$		d										
cier	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause											
Physician/N	Part II. Other significant conditions of	ontributing to death but not r		23b. Did tobacco use contribute to the cause of death?								
by		Oth Man subsectivelines										
Completed				24a. Wes an autopsy performed? 24b. Were autopsy fin available prior to completion of call								
du			of death?									
Š						10	Yes 2 No	1 Yes 2 No				
Bec	25. Was case referred to medical				26. Place of D	eeth (Check only	one)					
To	examiner? 1 Yes 2 No	Hospitet: 1 Impatient 2										
	27. Manner of Death	28a. Date of Injury (Month, Dey Year)										
읇	1 Content 5 Pending investigation) Injury		Yes 2 □ No							
Certification:	3 Suicide 6 Could not b					28f. Location (Street and Number or Rural Route Num						
F	4 Homicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)											
	29a, Certifier 117 Certifying Ph	ysician: To the best of my k	ranwledge deeth occ	urred at the tim	ne date and ola	ce, and due to the	e cause/s) and mai	nner es etated				
edical	(Check only 2 Medical Exam	niner: On the basis of exami	inetion and/or investig	gation, in my o	pinion, deeth oc	curred at the time	, date end plece, a	and due to the cause(s)				
ž	29b. Signature and title of certifier	mornior arened.		29d. Dete signed	(Month, Day, Year)							
4		и -		29c. License	CHARLES		Q1					
1	J ma				50164	•	876	0/99				
1	30. Name and address of person who		tem 23a) (Type, Print))								
	LIJE MANHEN											
tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	neture									
trar	AUG 1 1 1999	- La Company	D. No	outs								



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Physician Justine M. Metzger 8 11:30AM August /Medical 4a Facility Name (If not institution, give street and number) 4h. City. Town. or Location of Death 4c. County of Death **Examiner** Ellicott City Howard St. Agnes Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Aug. 13 1903 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F 95 219-16-8176 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD. Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3113 Elmmede Rd. 21042 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, Whita, atc filed within 72 hours after Hygiene. Wher than "natural", or ite 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event, bhiss. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Bertha Schlinsky John Cooney 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3113 Elmmede Rd. Ellicott City, MD. 21042 Mr. Donald J. Metzger/Son 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 Cremetion 3 Removel from State 8-11-99 Woodlawn Cemetery Woodlawn, MD. 4 Donetion 5 DOther (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Fecility
Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23e. Penti. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** /Medical ALZHEIMERS DISEASE fmmediete Cause (Finel YEAR(disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included and or injury) Due to (or es a consequence of) 68760 thet initiated events resulting in death) Last Due to (or as e consequence of) Box P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART PAILURE of Vital Records, P 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed s certificate has b 1 ☐ Yes 2 1 No 1 Yes 2 No I or Attending Physician: after death. 25. Wes case referred to medical axeminar? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death

1 Neturel

2 Accident 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation 1 Yes 2 No Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hoepital o within 24 hours aft To the Funeral Di completely filled in 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of pertifie 29c License number AUGUST 10, 1999 who completed cause of death (Item 23a) (Type, Print) ELLICOTT CITY MO 9501 OUD AM APOULS RD MAURER WD

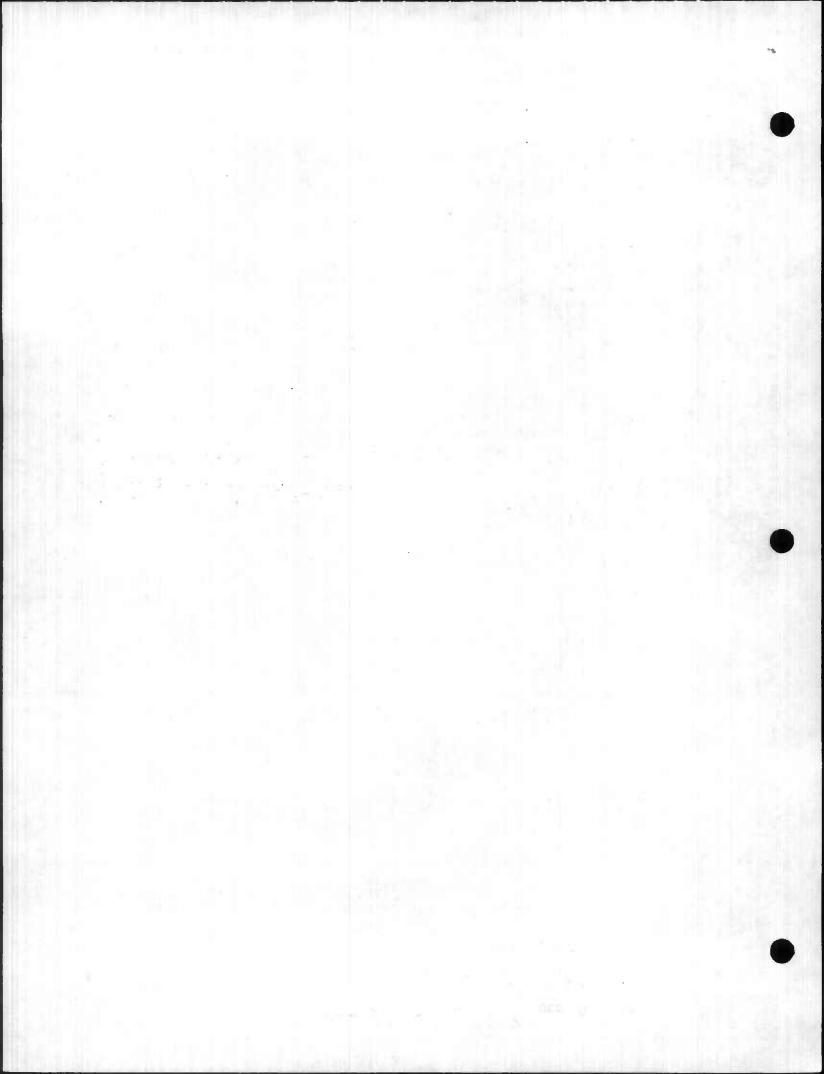
State Registrar

DHMH 16 Ray 6/95

31. Date filed (Month AUG

32. Registrar's Signeture

21042



Box 68760.

Division of Vital Records, P.O.

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month **Physician EDWARD** EUGENE MARTIN August 4, 1999 8:50 A.M. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner HOWARD MD 21052 VA MEDICAL CENTER, FORT

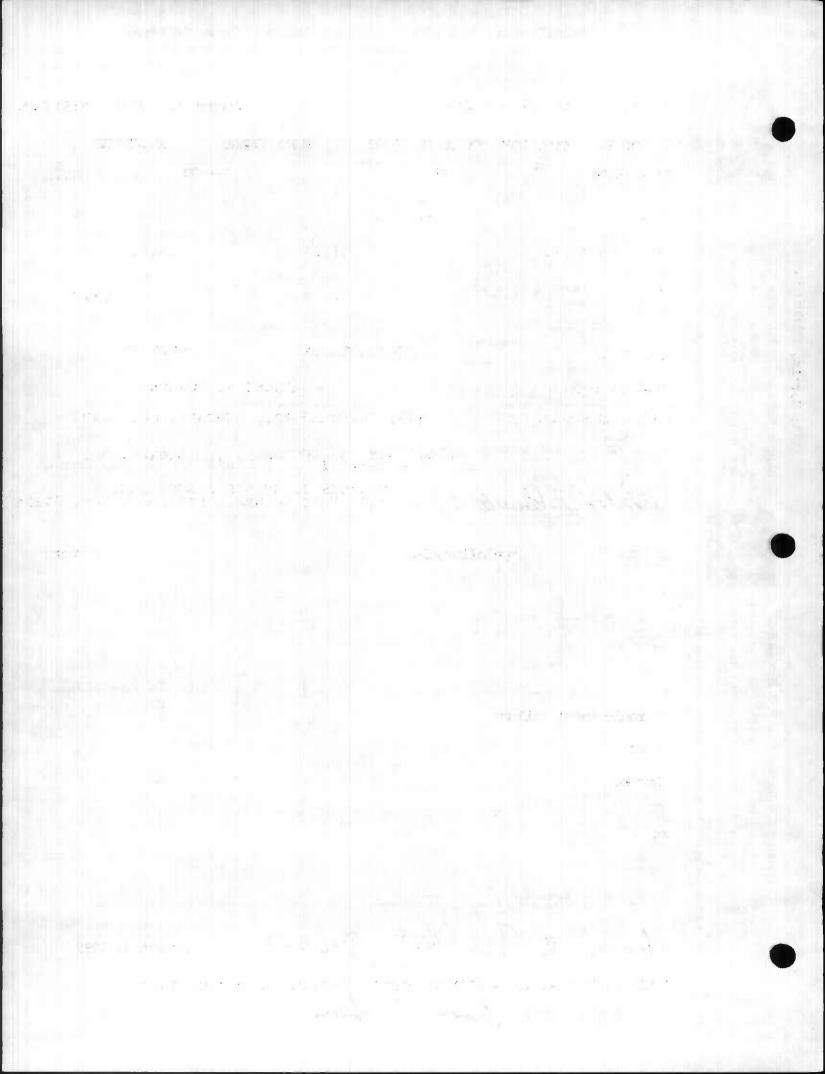
5. Sociel Security Number 6. Sex FORT HOWARD If Under 24 Hrs. 8. De BAL TMORE Birthplece (Stete or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number **Funeral** Deys Hours Months 12 M 20 F Director 214-26-5090 MD. Usuel Residence of Decedent death with the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD. N/A BALTIMORE 1 Yes 2 □ No Director 10g. Cifizen of Whet Country? 10f. Zip Code 10e. Street and Number 3520 BANK ST. 21224 U.S.A. Funeral 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 72 hours aftar 1 Never Married 2 ☐ Merried 1 Yes 2 No 1 Yes 2 No Specify: Specify: WHITE P 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) HELPER/TRUCK BREWERY UNKNOWN 7 is marked other traumatic event, [17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pagas 1 and 2 should be nant of Haalth and Mantail JOHN C. MARTIN AUDREY E. CORKRAN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) AUDREY SCHORR/SISTER Haalth a 8532 KAVANAGH RD., DUNDALK, MD. 21222 or othe 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete Dete 20e. Method of Disposition cemetery, cremetery or other place)
BALTIMORE WASHINGTON
CREMATORY 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State LAUREL, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 8/5/99 22. Neme end Address of Fecility CHARLES S. ZEILER & SON, 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. MD. 21224 Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical Myelofibrosis 2 years Examiner Due to (or es e consequence of): Examine physician and s the burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 45 attanding for usa as signed by tha a d be datached f 23b. Did tobecco use contribute to the cause of death? Pert it. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Ves 2 No 3 Probably 4 Unknown Chronic Renal Failure ρ should b 24b. Were autopsy findings evelleble prior to 24e. Wes an eutopsy performed? Completed Cout completion of cause of deeth? i cartificata has b lirector, paga 2 s 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Stroke or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☑ Inpatient 2 ☐ ER/Outpetient 3□ DOA this funeral 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Naturel 5 Pending investigation n 24 hours aftar death.

Per Funeral Director: Af blataly filled in by tha fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide edical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted. To the Hosp within 24 ho To the Fune complately f (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of cartifier 29c, License number aur, August 4, 1999 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) AURORA C. TAN, M.D., VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052 31. Dete filed (Month, Day, Year)

State Registrar

AUG 1 1 1999

32. Registrer's Signature oaks

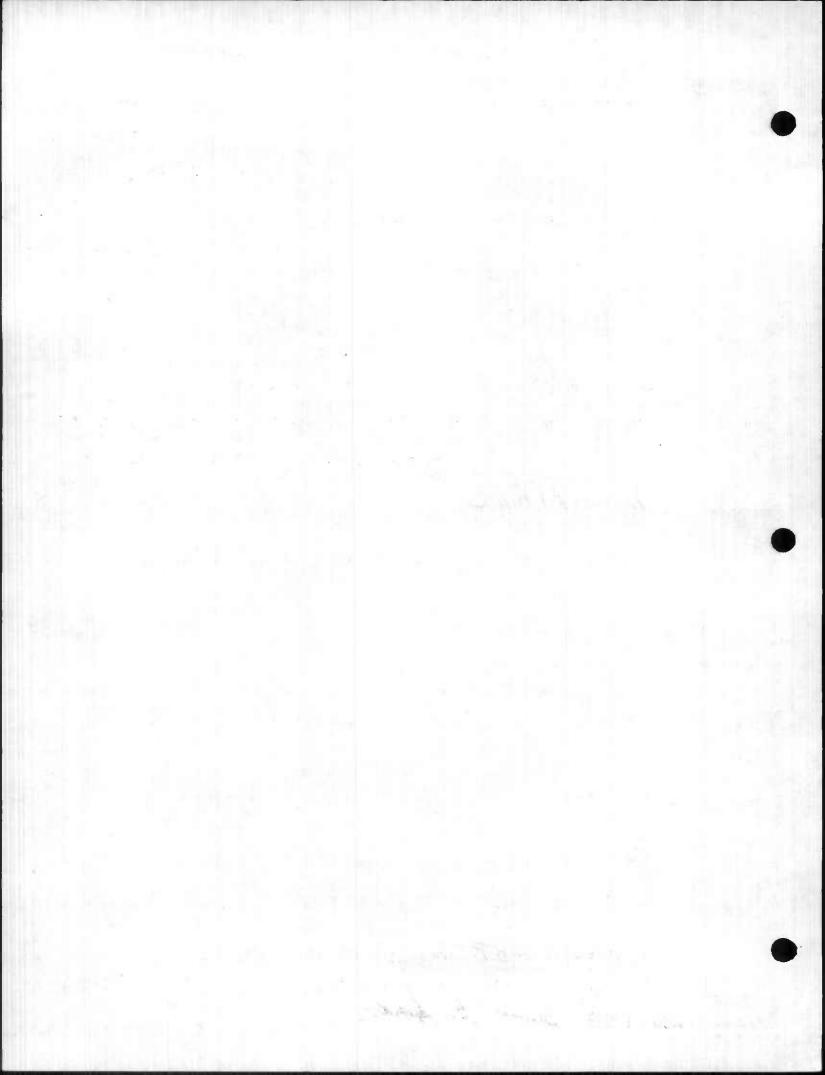


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Helen Marie Otto 5, 1999 6:24 p.m. August /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. The Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours 65 212-30-0282 1934 Director 12, Maryland Usual Rasidence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Madical Examiner must be notified at 1 Yes 2XNo Director Maryland Baltimore Co. Kingsville 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 11206 Cedar Lane 21087 United States Norms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Heelth and Mental Hygiene. Introcramt: if Nem 27 is marked other than "natural," or Nem any Injury or other treumatic event, the mental pages. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Health Care Registrar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Charles Fangmann Μ. Lawrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) (Daughter) 7 Old Maple Court Baltimore, Maryland 21221 Mrs. Dianne Colley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 8/7/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Parkwood Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Christina L. David 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 Myshna d 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart laiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner that the death certificate be executed physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): USe I 23b. Did tobacco use contribute to the cause of death? Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown non by The law requires 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed page 2 a 2 No 1 Yes 20 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 27. Menner of Death 1 🕅 Netural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Affer 5 Pending investigation death. 1 Yes 2 No Director: A 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) a 24 hours after of Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29e, Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 4,070 August 11, 1999 30. Name and address of person who completed cause of death (Item 23s) (Type, Print) 120 Sister A. Ramzy, T 31. Date liled (Month, Day, Vidr) #501, Towson, Taryland 21204 32. Registrar's Signature State

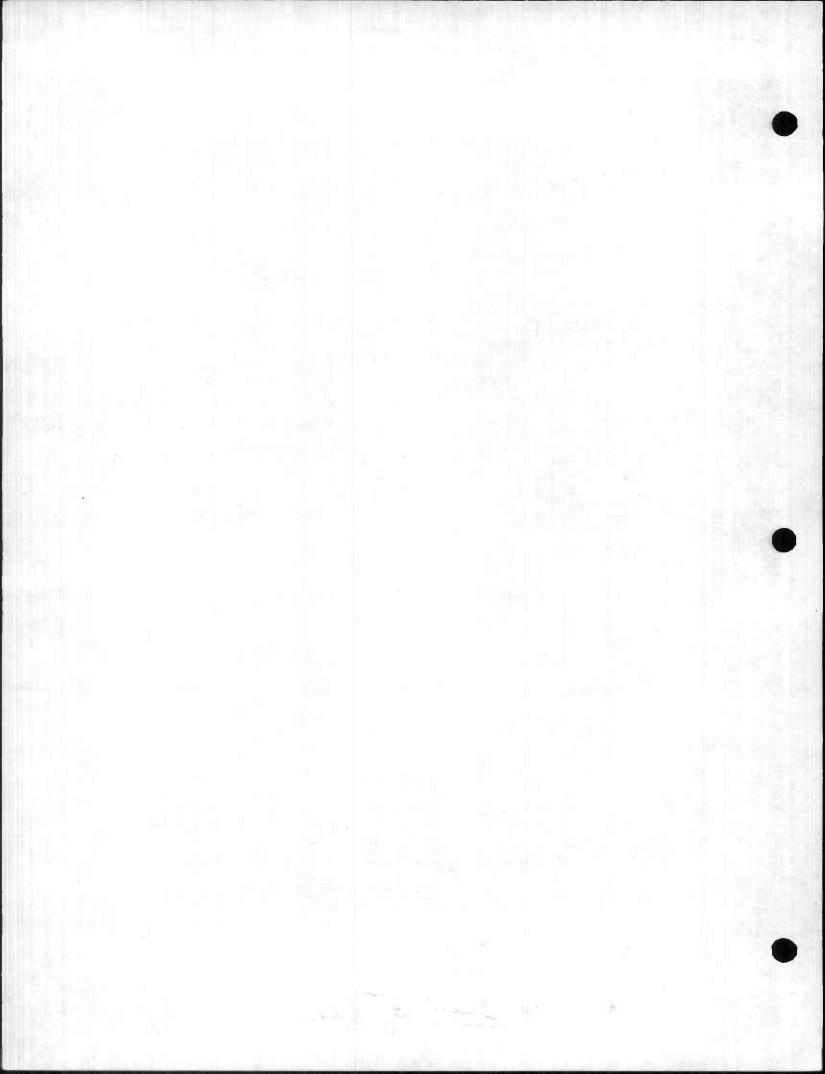
Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 **Physician** JOSEPH DSTERHELDT 0320 07 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner UNIV OF MARYLAND MEDICAL SYSTEM BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11 M 20 F 212-86-3732 27 Director OCT. 5, 1971 Maryland Usual Residence of Deceden permit. Peges 1 and 2 should be filed within 72 hours effer death with the Merylan Department of Heelth and Mentel Hygiene. Important: if Nem 27 is marked other than "natural", or Nems 23s or 28s-f show with injury or other treumatic event, the Medical Examination and pends and page. 10a State 10c. City, Town or Location 10h Count 10d. Inside City Limits 1 Yes 2 No Director Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 1608 Four Georges Ct., Apt. A3 USA Funeral 14. Raca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 9 Construction Buildina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Richard Osterheldt Patricia Ann Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Osterheldt - mother 1608 Four Georges Ct., Apt. A3, Baltimore, Md.21222 8/Date 14/99 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State Baltimore Washington Crm. Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lige 22. Name and Address of Facility Gary L. Kaufman Funeral Home@MeadowridgeMP, 7250 Washington Blvd., Elkridge, Md. 21075 7250 Washington Blvd., Elkridge, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) HERNIATION Examiner Due to (or as a consequence of) Examiner ASTROCYTOMA physicien end the burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest and the cause of the cause Due to (or as a consequence of) Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): . P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pege 2 a 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) To 1 Yes 2K No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? Atter Hatural 5 Pending To the Mospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 TYes 2 □ No 2 Accident 6 ☐ Could not be 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29b. Signature and title of certified 29c. License number 29d. Dete signed (Month, Dey, Year) MD # 12429 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEAHAN R HANNA, MD 22 SOTH GREENE ST BALTIMORE, MD

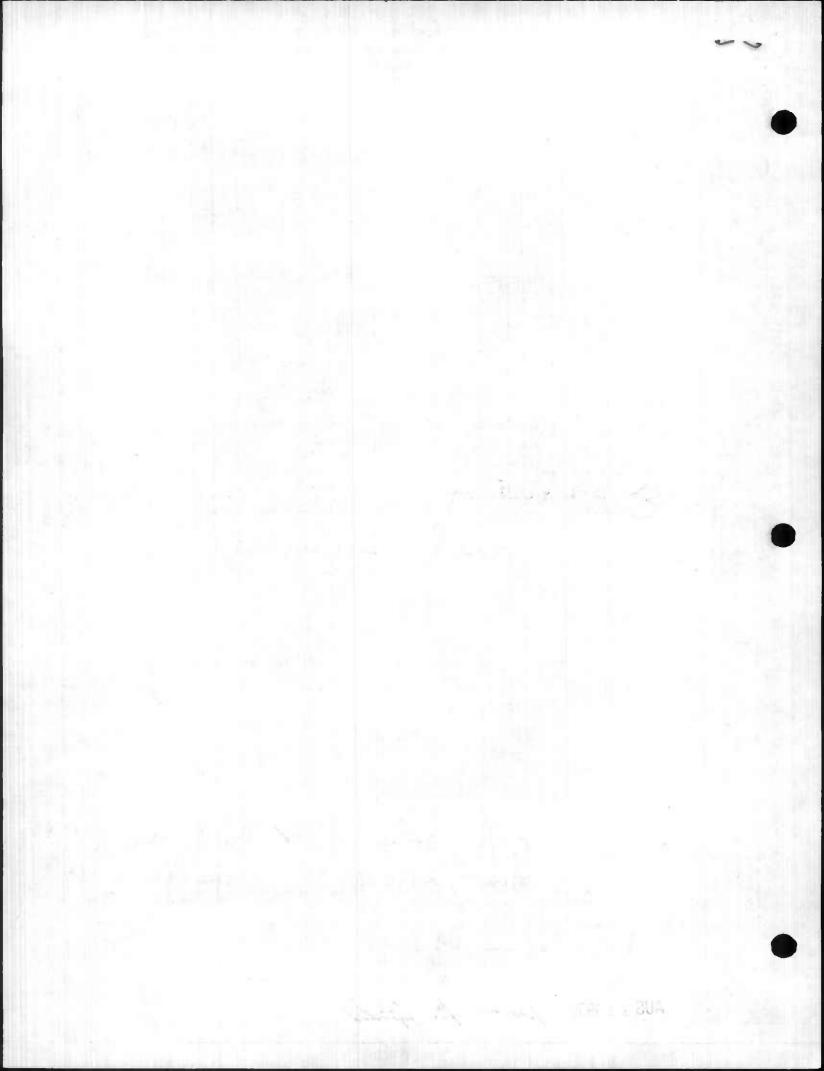
State Registrar 31. Date filed (Mont



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AMES OIST		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 99 25224													
No.	nysician	Decedent'a Name (First, Midd		Month	2. Date of Death Month Day Year 3. Time of										
L	Medical xaminer	James 4a Facility Name (If not institution	Edwar n, give street and r		Poist		4b. City, Tow	AUGUS' n, or Location of Dea	AUGUST 08, 1999 22:57 PM Location of Death 4c. County of Death						
		UNIVERSITY HO	SPITAL					IMORE	N	/A					
	neral ector	5. Social Security Number 219–96–2671	6. Sex 1 X M 2 □ F		yrs. last birthday 9 Yrs.	Months Days		Min. (Month, C	irth Pay, Year) 5, 1970	Year) Country)					
2 >		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or L	ocation				Land Inside City					
death with the Maryland	rector			100.							0d. Inside City Limits 1X Yes 2 □ No				
the	Directo	Maryland 10e. Street and Number	N/A		Ва	ltimore 10f. Zip Code			10g. Citizen of What Country?						
with		27 N Kre	sson		U.S.A.										
ter deat	ober mest Funeral	11. Marital Status		ecedent Ever i Forces?	n U,S. 13.		L 224 Hispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)	1	e - Americ ck, White,					
3 2 5	- E	1 Never Married 2⊠ Mer	ried 1 Tes	s 2K No Give		1 ☐ Yes 2X No		r dello riioan, etc.)	Specify	v.					
72 hours	d by	3 Widowed 4 Divorced		Dates:	460 D-00	death Head Occ				W	hite				
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H H	Be C	17. Father's Name (First, Middle,	_				18. Mother	s Name (First, Middl							
Waryland 2 12 should be filed who and Mental Hygie		Gary T. Po	ist, Sr				Vict	oria L	Lee Van Metter						
2 shoand	traumatic	19a. Informant's Neme/Relations	or Rural Route Num	ber, City or Town,	State, Zip	Code)									
1 and Health	ě	Mr. Gary T. Po	oist, Sr.			Curtis Av	renue E	Baltimore,			- 01-1-				
Pages nent of h	9	20e. Method of Disposition 12 Burial 2 Cremation		m State	cemetery, cre	matory or other pla				20c. Location - City or Town, State Elkridge, Maryla					
Semit. Pages Separtment of Important: If the	n lucy	4 Donation 5 Other (S		I.V.		dge Mem.		8/12	Elkridg	e, Ma	ryland				
Dalltimore, M permit. Pages 1 and 2 Department of Health 1 Important: If them 27 is any Injury or other tra	pope	21. Signature of Funerel Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc.													
_		23a. Part 1. Enter the diseese, or	complications that	t caused the	. 8	728 Liber	ty Roa	d Randal	1stown,	MD 2	Approximate				
Physician /Medical Examiner	dical niner	Immediate Ceuse (Final disease or condition resulting In death) Due to (or as a consequenca of): Interval Between Onset and Death Due to (or as a consequenca of):													
e be executed	the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury c.													
certific	USO BS	that initiated events resulting in death) Last	d	Due to	o (or as a conse	quence of):				1					
. 0 0	ed lor	Part If. Other eignificant condition	ons contributing to	death but not	resulting In the	underlying cause gi	ven in Part f.	23b. Did	tobacco uee co	ntribute to	the cause of death?				
that the	d be detached for use at by Physician/M			10	1 Yee 2 No 3 Probably 4 Unknown										
D 00 00	shoul			24a. Wa	24a. Was an autopsy performed? 24b. Were autopsy find available prior to completion of cau of deeth?										
The law	age 2							15	Yes 2□No	10	Yas 2 No				
	director, page	25. Was case referred to medical 26. Place of Death (Check only one)													
Physician:	To 8	axaminer? 1X Yes 2 No	Hospital:	sing Home 5 Res	sidence 6 Oth	er (Specif	1)								
B 5	fune	27. Menner of Deeth 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation 8 K	Pedes.	how injury occur	rich	ek by								
To the Hospital or Attendit within 24 hours after death.	illed in by	4 ☐ Homicide determ	ined 200/Plain	Pau	281. Location (Street and Number or Rurel Route Number, Cascor Town, Steta)										
Hos 24 ho	pletety fill		Examiner: On the					plece, end due to the occurred at the time							
To the Hospital within 24 hours To the Funeral	Me	29b. Signature and title of certifie		a delete.	. 0	29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)				
) - *-	0,	1 & Pu		AUGUST	г 09,	1999									
d	XI	30. Name and address of person	ph Yo	estan	CE 111 1		et, Ba	ltimore, N	Maryland	2120	1				
	State	31. Date filed (Month, Day, Year)	1 32.	Registrar's Si	griature	1 . 25									

Ang T T 1999.



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death AMEND#18 PER F.H. G774 8-11-99 J,A. Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima ot Death Dey 1999 **Physician** 5, CATHERINE M. POETZEL AUG. 4:00 A.M /Medical 4e Facility Neme (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8620 WILLOW OAK RD. N/A BALTIMORE Hours Min. 25, SEPT. 19 If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months 1 M 2 JF 216-54-48-23 88 **Director** MD. Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits ham 27 is marked other than "natural", or hams 23s or 28s-f show other traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo BALTIMORE N/A MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 WILLOW OAK RD. 21234 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian. 11. Merital Stetus Black, Whita, atc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) se filed within 7 is I hygiene. Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 6TH 18. Mothar's Neme (First, Middle, Maiden Sumeme) BRISTCKY permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any Injury or other traumatic avant page. 17. Father's Name (First, Middle, Last) SAMUEL J. BOND FRANCES UNKNOWN 19a. Informent'a Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) KATHLEEN DAMICO/DAUGHTER 8620 WILLOW OAK RD., BALTIMORE, MD. 21234 20a. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) SACRED HEART OF JESUS 8/7/99 BALTIMORE, MD. 21. Signature of Funerel Service Licensee 22. Nama end Address of Fecility CHARLES S. ZEILER & SON, INC. MO0621 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart tailure. List only one cause on each line. BALTIMORE, Approximate Intervel Batween Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting In deeth) /Medical Examiner Examine physician and the burial-transit the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted eventa resulting in death) Last Box 68760 Physician/Medical Due to (or ea a consequence of): P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably ★ Unknown Records. þ 24b. Wera autopsy tindings available prior to completion of cause of deeth? Completed 24e. Wea en autopsy performed? has 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa retarred to medical axaminer? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home TResidence 6 Other (Specify) Hospital: 1□ Yes 2□ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) ours after death. eral Director: After th filled in by the funeral 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred edical Certification: To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After 5 Pending investigation Natural 2 Accident 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 D Homicide XX Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) CYND 00 D08358 Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print) S. CLITOM ST 703 T. KaD 31. Date tiled (Month, Day, Year) 32. Registrer's Signatura State Registrar

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Please Type or Print in Biack indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month Dav NORMAN REICH AUGUST 09 1999 1954 4b. City. Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE CITY 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) JULY 11, 1 Birthplaca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Yrs. 1923 069-16-7005 76 NY Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yas XXNo BALTIMORE TIMONIUM 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? #302 U.S.A. 2400 CHETWOOD CIRCLE 21093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amaricen Indian, Black, White, etc. 11. Marital Status 1 ☐ Yas 2X No If Yes, Give Yaar or Datas: 1 □ Nevar Marriad 2 □ Married 1 ☐ Yes 2 X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CHEMICAL ENGINEER U.S. GOVERNMENT 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) BENJAMIN REICH MOLLIE ROVNO 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ELLEN REICH / DAUGHTER 2125 E. BALTIMORE ST. - BALTIMORE, MD 21231 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) REISTERSTOWN, MD BALTIMORE HEBREW CEMETERY 8/11/99 22. Nama and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 caused the daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a CORONARY ARTERY DISEASE 06 YEARS Due to (or as a consequence of) AORTIC VALVE DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? complation of causa of death? 1 ☐ Yes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 ☐ Inpatient 2 ☐NER/Outpatlent 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

The law requires that the death certificate be executed physician and s the bunal-trans 88 USB S ed by the a should certificate has b lirector, page 2 s Aftar this death.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or then any injury or other traumatic event, the Medical Examination.

Physician

/Medical

Examiner

Physician/Medical Examiner

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Completed

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Certification:

edical

Baltimore, Maryland 21215-0020

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death with the Maryland

P.O. Box 68760 Division of Vital Records, or Attending Physician: 3 aftar • Funeral Dire letely filled in b Hospital within 2 To the

> State Registrar

31. Date file 11 AUG

29a. Certifier

(Check only one)

29b. Signature and title of certifie

1999

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and dua to the cause(s) and manner stated. 29c. Licensa number

29d. Date signed (Month, Dey, Year)

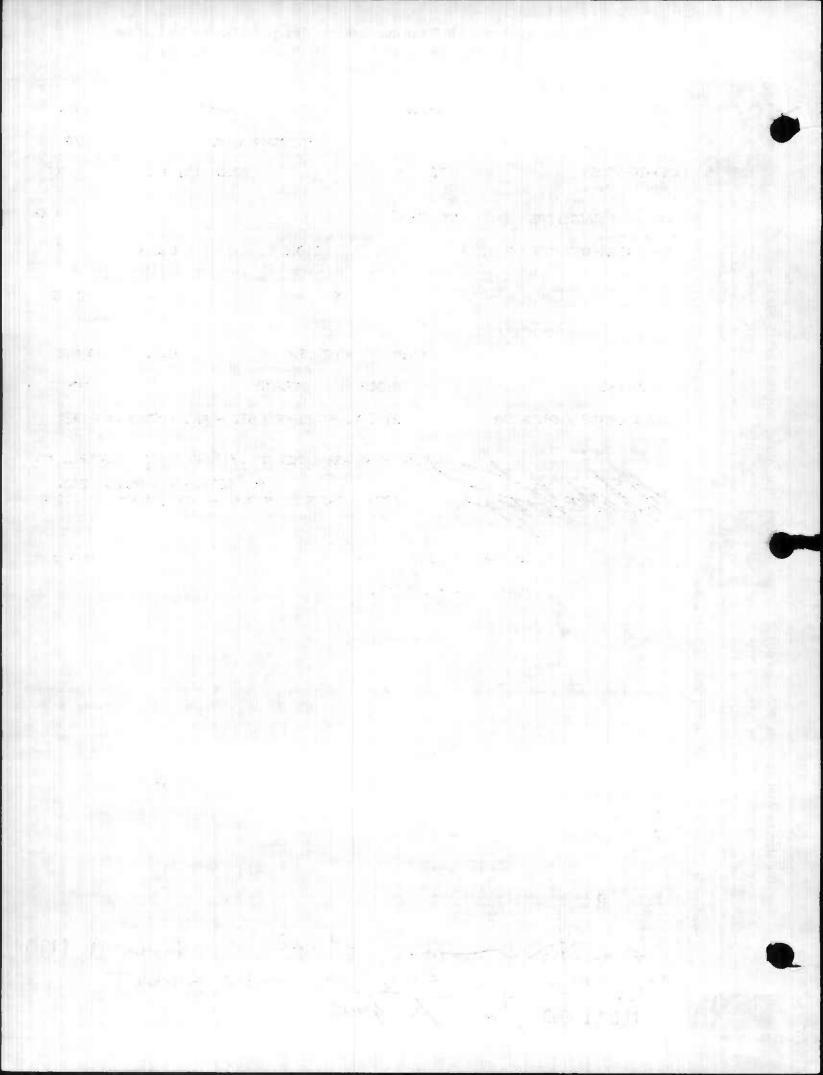
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1 🔀 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end manner as stated.

30. Neme who completed cause of death (Item 23a) (Type, Print) and a dress of person anmoquem U

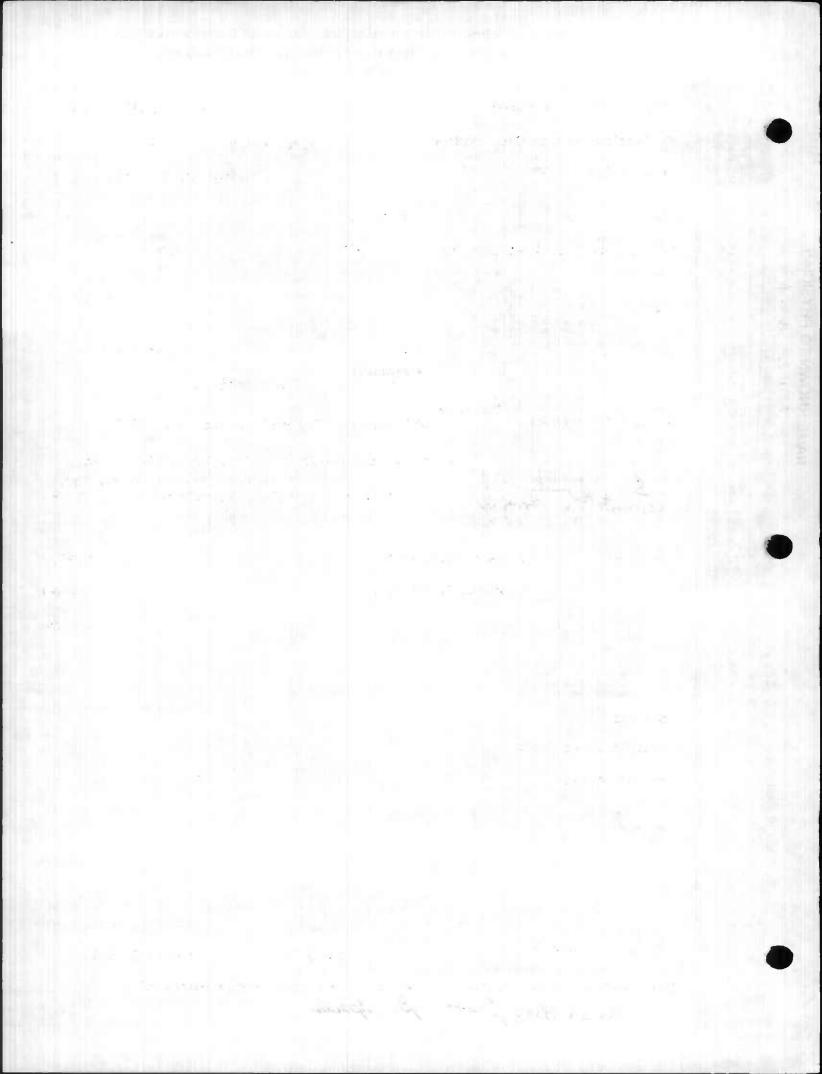
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2. Registrar's Signature



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Physician	State of the state	me (First, Middle, Matthew]		2. Dete of Dee Month	Dey	Yeer 3. Time of Death									
/Medical		(If not institution,		August											
Examiner		land Hea		Dint Cecil S. 8. Date of Birth 9. Birthplece (State or Foreign											
Director	212-20- Usuel Residence	of Decedent	½ M 2□ F	86	Yrs.	Months De	ys Hours Min.		0, 1913	Md.					
M. deeth with the Menyland ms 23a or 28a-f show rmat be notified at	Md.	n/a		10c. C	Balt	imore			1 ∕ €XYes						
1n M. Unter death with the Meltine 23e or 28e-f second in the meltine for the format be need in the format by the		29th Stre				10f. Zip Code 2121	8								
LV1D 020 urs after ser, or the	PRODUCTION OF THE PROPERTY OF	orried 2 Married 4 Divorced	Armed Fo	2 □ No ive		wes Decedent of f Yes, specify C	of Hispenic Orlgin? (Suban, Mexican, Puerti No Specify:	pecify Yes or No- o Rican, etc.)		yeer 999 6:05 A.M. unity of Death coil 9. Birthplece (State or Foreign Country) 10d. Inside City Limits 12 Yes 2 No. 10d. Inside City Limits 1					
Phin 211	(Sp.	15. Decedent's ecify only highest (condery (0-12)	Education grade completed) College ((Give	dent's Usuel Oct kind of work do DO NOT use ref	cupetion ne during most of wor ired)	king							
Maryla 12 should 12 should h and Men 1 s marke reumatic	3rd Grad	de e (First, Middle, La	est)		Chef	own	18. Mother's Nen		Meiden Sumem	City or Town, Stete, Zip Code) Md. 21157 20c. Location - City or Town, Stete Baltimore, Md. eral Homes, Inc. timore, Md. 21216 Approximate Interval Between					
	19e. Informent's Name/Reletionship (Type, Print) Daughter 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, 2)														
Heal Heal	1) Control 2 Cremetion 3 Removel from State cemetery, cremetory or other place)														
Baltimore, pemit. Pages 1 a Department of Hee Important: If them any lojury or othe	Arbutus Memorial Park Aug. 13 Baltimore, Md. 21. Signature of Funeral Service Licentee 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216														
Physician	23a. Pert 1. Enter shock, or he	r the diseese, or co eart failure. List on	omplicetions hat aly one ceuse on	caused the deceech line.			trying, such es cardiac			Approximete Interval Between					
/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death) Severe Hypotension Bue to (or es e consequence of):														
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The law page 2	Modular Goiter														
of Vital I Physician: The rthis certificate and director, page 1: To Be Co	25. Wes case referred to medical exeminer?									(one)					
Division of Vita To the Hospital or Attending Physician: Within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (1 Yes 2 27. Menner of De 1 Naturel 2 Accident	4 h	28e. Date	Inpatient 2 [of Injury oth, Dey Year)	28b. Time o	f 28c. Ir	4X Nursing H	Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred							
Division of Attending P rs after death. a) Director: After tied in by the funer Certification:	3 Sulcide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)								28f. Location (Street end Number or Rural Route Number, City or Town, Stete)						
Hospital 24 hours Funeral tely filled	29a. Certifier (Check only one) 1 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examinar: On the bests of exemination end/or Investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated.														
To the vithin 2 To the comple	29b. Signeture er				ense number		29d. Date signed	d (Month, Dey, Year)							
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	****	dress of person wh			4-1-1										

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Dolores Reeves 8/10/99 7:05 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5408 Catalpha Road N/A Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplaca (Stata or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days Hours 216-28-3821 1□M 2☑F 67 Months Yrs. **Director** Usuai Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits a pos MD N/A Baltimore DCYas 2 No Directo 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò must be 5408 Catalpha Road 21214 U.S.A. Barrie 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Bleck, Whita, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Self Employed Manager Pages 1 and 2 should be filed nent of Health and Mental Hygi-int: If Item 27 is marked other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Bernard Hartman Evelvn Buchingham 19a. Informant's Neme/Raiationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any injury or other tra James Edwin Reeves 5408 Catalpha Road Baltimore, Maryland 21214 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata Dulaney Valley Cemetery 8/13/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility John C. Miller Inc. 21. Signature of Funeral Selv 6415 Belair Road Baltimore, Maryland 21206 or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Cause (Finel disaase or condition rasulting in daeth) /Medical Examiner to (or as a consequence of) Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) nse 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 20 No 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28b. Time of 27. Mennar of Death 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending invastigation 1 Yes 2 No hours after death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routs Number, City or Town, State) 28a. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide filled in To the Hospital o within 24 hours af To the Funeral Di completely filled i 1 Notes that Description Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Charles

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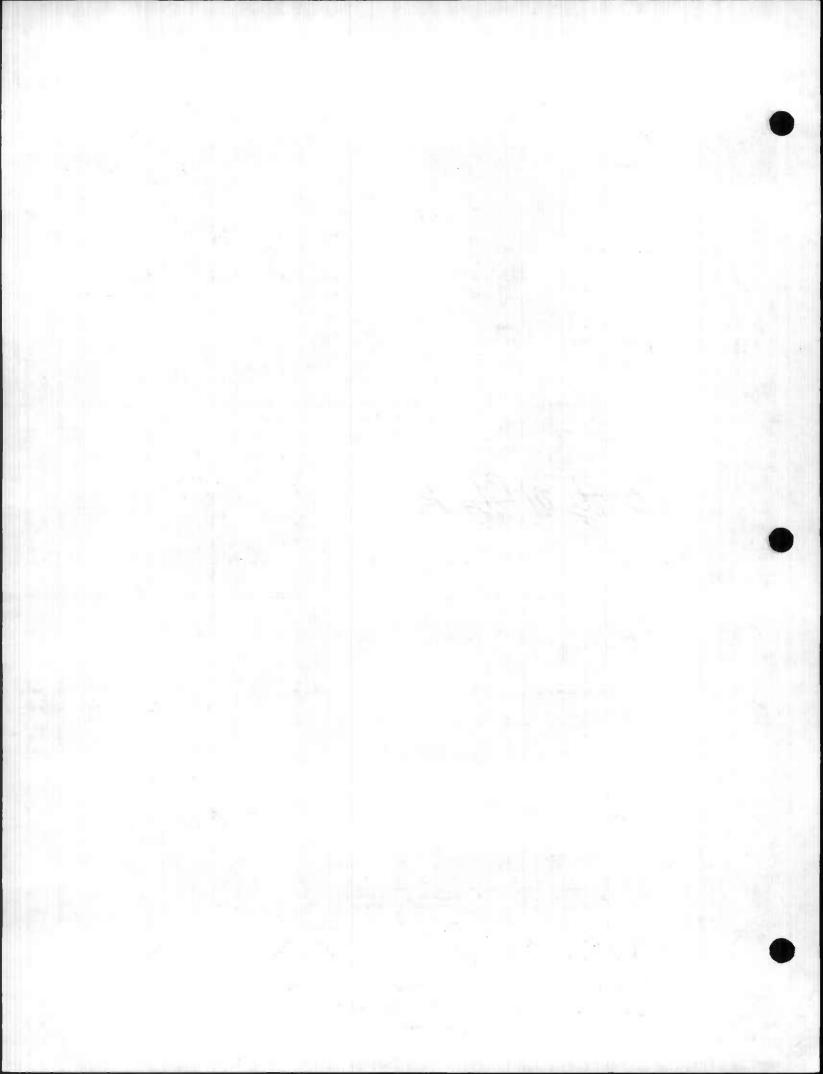
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lusa of death (Item 23a) (Type, Print)

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32. Registrar's Signatur



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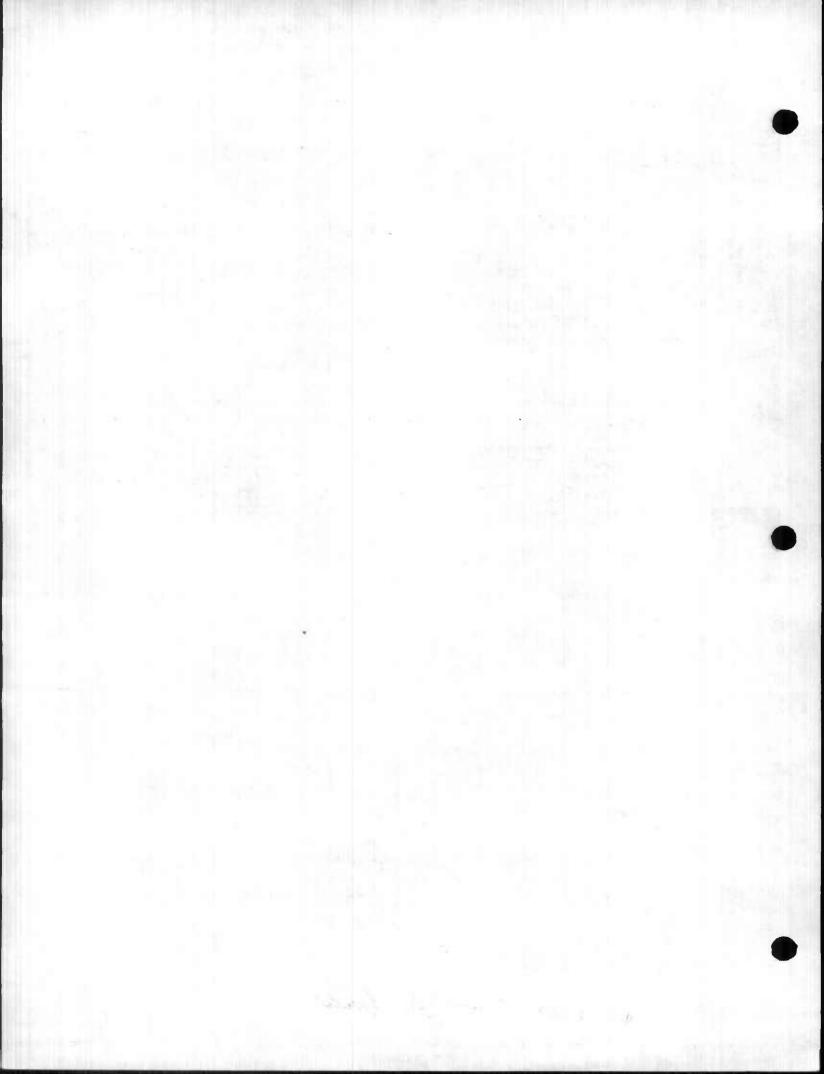
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** AUGUST 8, 1999 MEYER SOKOLOW 8:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE HOMEWOOD 2700 N. CHARLES ST. BALTIMORE N/A If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) AUG. 13, 1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15 M 20 F 218-22-8676 70 Yrs. MD Director Usuei Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Directo BALTIMORE OWINGS MILLS 280-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 4603 SPRINGWATER COURT #B 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? WWII & Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. hours after 1 Yes 2 No KOREA Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0020 WHITE 1 ☐ Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 filed within Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) EMPLOYMENT REPRESENTATIVE BG&E CO. permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy importants if New 27 is marked other any Injury or other V 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 MORRIS SOKOLOW SARAH STUTZ 19a. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE A. SOKOLOW / WIFE 4603 SPRINGWATER COURT #B - OWINGS MILLS, MD 21117 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 8/10/99 4 Donation 5 Other (Specific MD VETERANS CEMETERY OWINGS MILLS, MD 21. Signature of Por 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart failure. List only one cause on each lina. Approximate interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner to (or as a consequenca of) Examiner The law requires that the death certificate be executed Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or es a consequence of): Part ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contributa to the causa of death? Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy tindings available prior to completion of cause of death? Completed 24e. Was en eutopsy performed? on disease SI Tracker story 1 ☐ Yes 2 No 1 □Yas 2 □ No of Vital or Attending Physician: 8 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of injury (Month, Dey Year) Inneral 28d. Describe how injury occurred 27. Mannet of Death 28b. Time of 28c. Injury at Work? After Division 1 Naturai 5 Pending investigation s after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and placa, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier death (Hern 23a) (Type, Print) Loyal Ave, Baltinne MD 21217 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State AUG 1 1 1999

DHMH 16 Ray 6/95

Registrar



altimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PT I, 27, 28A-F PER Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 0950 AM Otis Stallings, AUGUST 3, 1999 /Medical 4e Fscility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LORIEN-COLUMBIA NURSING HOME COLUMBIA HOWARD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Days 15M 2□ F 165-44-2197 43 Yrs. Director Nov. 21, 1955 PA Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits MD TOYes 2 No Howard Columbia Maryland 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 눕 6334 Cedar Lane 238 21044 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. filed within 72 hours after Yes ZNNo Never Merried 2 Merried 8 1 Yes X2 No Specify: **Black** Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Unkalife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unk. Elementary/Secondery (0-12) College (1-4or 5+) 10 0 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Otis Stallings, Addie Perry 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . nt of Health a If hem 27 is or other tra-Samuel D. Perry / Uncle 3016 Depaul Ct. Charlotte 28126 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlel 2 ☐ Cremetion 35 ☐ Removal from Stete August 13,1999 Ahoskie, Hilcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Victor P. Doda, Jr. 22. Name end Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, BAltimore Maryland 21230 C Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediete Cause (Final disease or condition resulting in death) /Medical HEAD INJURIES WITH LONG TERM COMPLICATIONS Examiner Due to (or as a consequence of) The law requires that the deeth certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical the Due to (or as e consequence of) 950 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2□ No 1 Yes 2 □ No or Attanding Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Universing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification: To 1XXYas 2□ No this 28a. Date of Injury 27. Manner of Deeth 28b. Time of Injury 6 15AM 28d. Describe how injury occurred Subject struck 28c. Injury at Work? 5 Pending Investigation 1 Natural UNKNOWN on head with blunt object death. 1 ☐ Yes 🛪 ☐ No 2 Accident efter death Director: Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) CHBJECT FOUND ALONG SIDE OF ROADWAY STREET 28f. Location (Street and Number of Rural Route Number C City or Town State) filled in by 4 Homicide UNK 900 CB MOCRE AVE, PHILA., PA To the Hospital o within 24 hours of To the Funeral D STREET 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Addical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier

State Registrar

S, Radentz 111 Penn Street, Baltimore, Maryland 21201 A2. Registrar's Signeture

30. Name and address of person who completed cause of death (Nem 23e) (Type, Print)

(Check only

Stephen

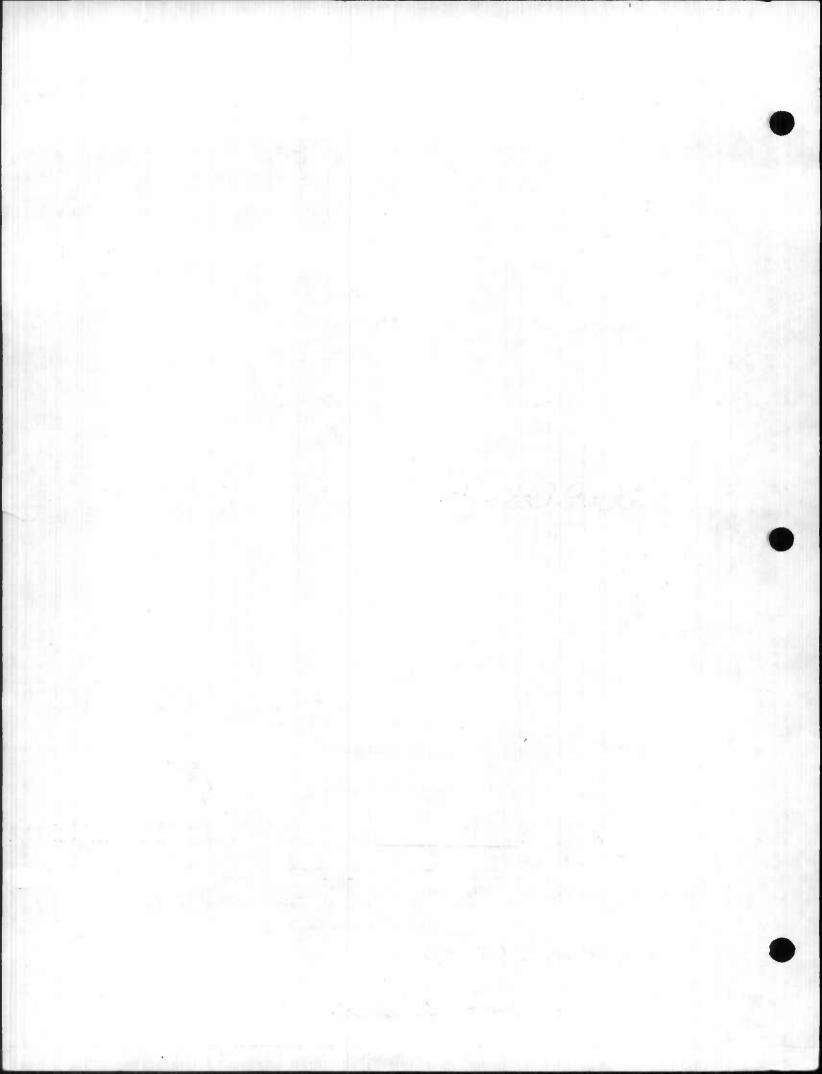
29b. Signeture and litle of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 10, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death SCHUSTER Month 420 Am Anconst 1999 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAMARITAN HUSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | 10 | Months 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (Stete or Foreign 1 M 2 XF 80 Baltimore

AMENDED ITEM #26 PER VERBAL RESP. G774 8/11/99 AH 1. Decedant's Nama (First, Middla, Last) FRANCES **Physician** /Medical 4a Facility Name (If not institution, give street and number) Examiner (1001) 5. Social Security Number **Funeral** 216-09-8554 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner round be notified at Baltimore Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4341 Burger Avenue 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ YNo If Yes, Give Yaar or Dates: 1 Never Married 2 Married specify: White 1 ☐ Yes 2 🕽 No Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Martha Hammer George Manns 19a. tnformant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4111 Montana Ave. Baltimore, Md. 21206 Robert Schuster- Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Na Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 8-6-1999 Gardens Of Faith Baltimore, Md. 21. Signatyle of Funeral Service Licenses 22. Name and Address of Facility any In Leonard J. Ruck Funeral Home Inc. 5305 Harford Rd. Baltimore, Md.

23a. First Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** RENAL DISEASE END STAGE /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Due to (or as a consequence of): ARTERY Physician/Medical Examiner CORUNARY physician and the burial-transit The law requires that the deeth certificata be executed Due to (or es a consequence of): Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last RSSPIRATORY FAILURE Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): ISCHEMIC 80

CARDIOMYOPATHY

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t.

23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 POnknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of causa of death?

Approximate Interval Batween Onset end Death

10d. Inside City Limits

1 X Yes 2 No

1 Yes 2 No

1 Yes 2 No

25. Was case referred to medical axaminar? 1 ☐ Yes 2 ☐ No

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Control (Specify) CS 28d. Describe how injury occurred

27. Manner of Death 1 Netural 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending Investigation 6 Could not be determined

28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one)

1 🗹 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner es stated. 2 Medical Examinar: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. Licansa number 0047891 29d. Data signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

AIGBEDION 0.

GOOD SAMARITAN

HOSPITAL BALTIMORE

State Registrar 32 Registrar's Signeture

ed by the a

signed by t

been sir

page 2 s

certificate

After this

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

or Attending Physician:

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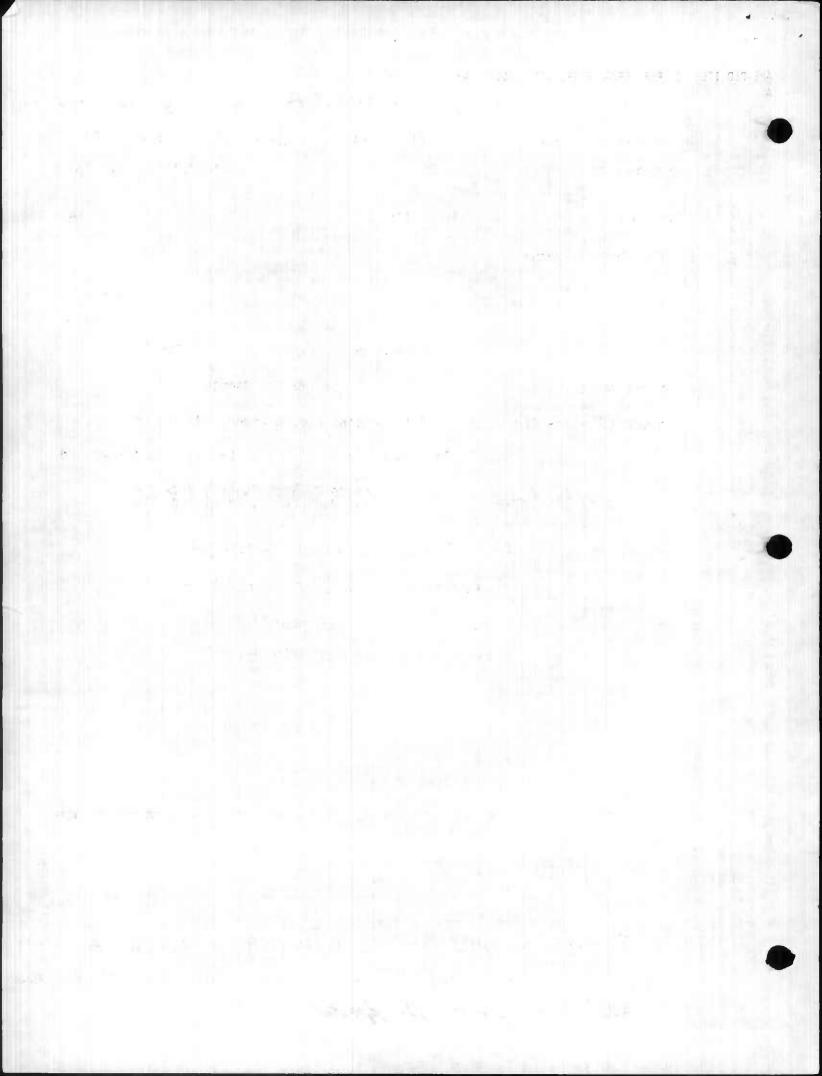
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2

Certification:

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Yeer Sharpe 09, 99 4b. City, Town, or Location of Deeth 1:27am 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Future Care Homewood Nursing Ctn. NA Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Hours 1 M 2 XF 220-14-2429 87 08-31-11 VA Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore ¥O¥Yes 2 □ No 10f. Zip Code 10a. Citizen of Whet Country? 1600 Mt. Royal 21217 Avenue Apt.#313 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. Yes 2 No f Yes, Give X reer or Detes: 1 Never Married 2 Married 1□ Yes 2□ No Specify: Black 3€Widowed 4 □ Divorced 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Various trades NA 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Surneme) Edwards Martha Chapple 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21217 19e, Informent's Neme/Reletionship (Type, Print) 1909 N. Monroe Street Baltimore, Maryland Evans 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Voshell Mem. Gardens 08-13-99 Dundalk, MD 21. Signeture of Funerel Servica Licansee 22. Name and Address of Fecility Baltimore, Maryland 21202 WM.C.MArch FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Onset end Deeth breast Carcinma Metastatic Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2XNo 1 Yes 3 Probably 4 Unknown 24b. Were eutopsy findings evallable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury e Work? 28d. Describe how Injury occurred 5 Pending investigation 2 No 1 Yes 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Physician /Medical Examiner The law requires that the death certificete be executed

P.O. Box 68760,

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items on any injury or other traumatic

Annie

5. Social Security Number

10e. Street end Number

8th Grade

Robert

Sadie

20e. Method of Disposition

Immediate Cause (Final diseese or condition resulting in deeth)

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest

exeminer

1 Yes

27. Menner of Deeth

1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

200 No

10a State

Director

Funeral

by

Completed

MD

pue physician Physician/Medicai the the ettending popular cate hes been signed by page 2 should be detect Completed by certificate hes or Attending Physicism: after death. Director: After this certifica Be 2 funeral Certification: filled in by the

To the Hospital e within 24 hours a To the Funeral D Medical 29b. Signeture end title of certifier

5 taw 29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

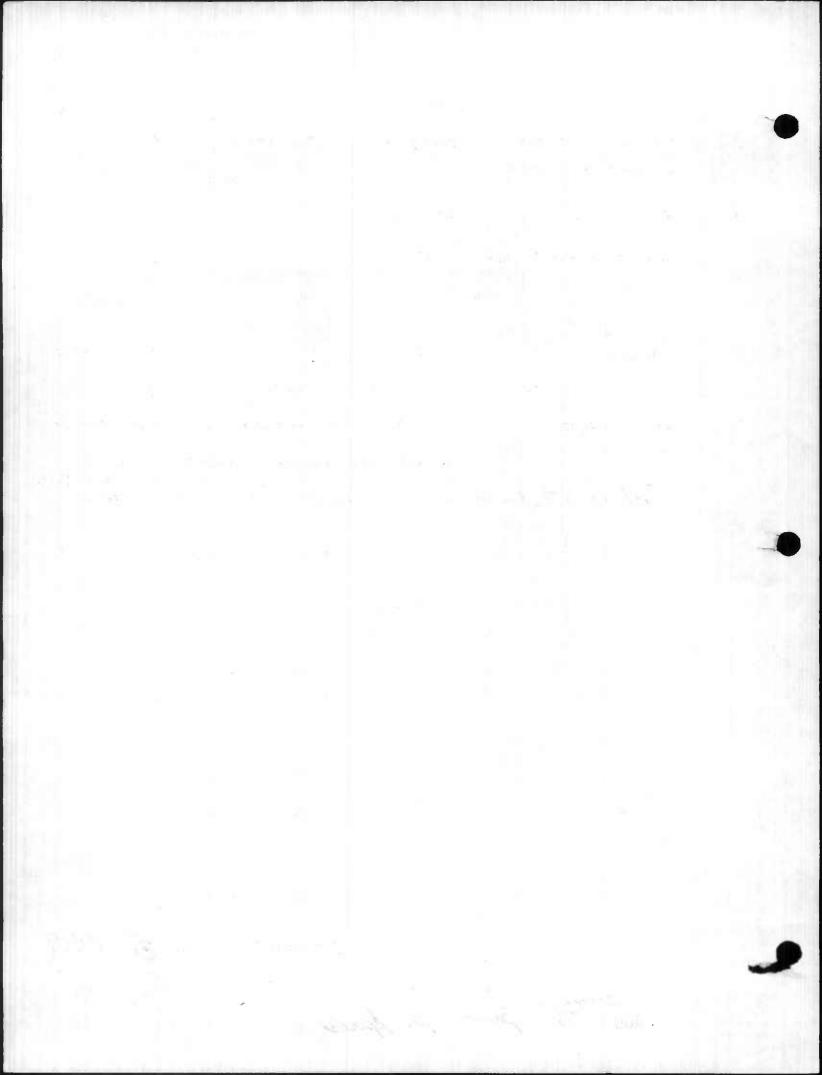
29d. Dete signed (Month, Dey, Year,

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Sabapathi Ramesh, MD

State Registrar AUG

32. Realstrer's Signeture

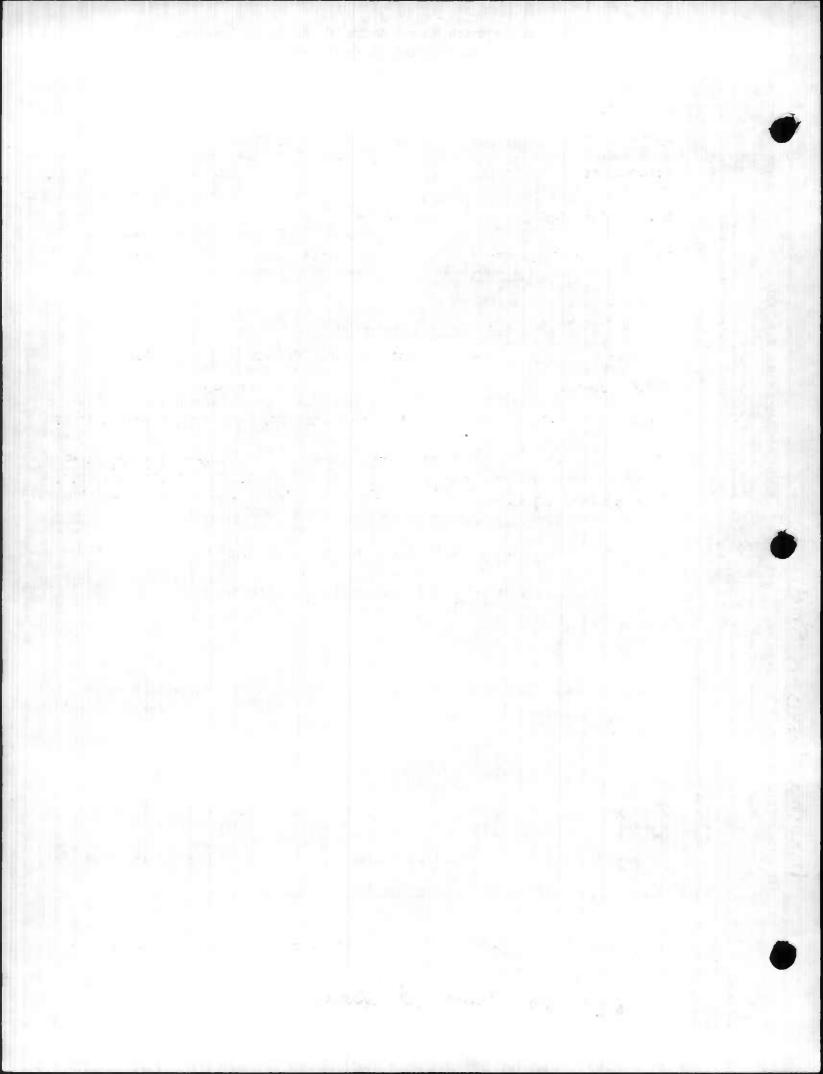


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State of Maryland / Department of Health and Mental Hygiene

25233

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35	th. : Afte	ig i	1 ⊠ Naturel 2 □ Accident	5 Pend Inves	ling tigetion	(Mo	nth, Day Year)	Inju	M M		Yes 2] No						
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6	afte Olre	er	4 Homicide	00101		build	ding, atc. (Spec	cify)					City or To	wn, Stata)				
	To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier (Check only one)			ner: On the I	basis of exemir							causa(s) and n data end placa			use(s)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. AMEND #10c&10d PER F H

1. Decedent's Name (First, Middle, Last) G774 8-11-99 .1 A 3. Time of Death 2. Dete of Death Day Month 2100 **Physician** 08 Stumpt 99 narles 06 /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical Center T

7. Age (In yrs. last birthday) | If Under 1 Year | Months | Deys of Baltimore N/A University 5. Social Security Number If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** M 2DF Hours 218-04-3679 82 Yrs. Director 01/12/1 MD. Usual Residence of Decedant the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits ahow of 2 should be filed within 72 hours after death with the Maryla. It hand Mental hygiene. 7 I a marked other than "natural", or itema 23a or 28a-f ahow traumatic avent, in Mental Emerican ment in hooding a 1 Tes 2 No DUNDALK Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Wes Decement Ever in U.S.
Amed Forces?
10 Yes 2 10 No
If Yes, Give WWII
Year or Detes: 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11. Meritel Stetus Bleck, White, atc. 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify:WHITE þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) AUTO TRANSPORTER TRANSPORT **12TH** permit. Pages 1 and 2 should be filet.
Department of Health and Mental Hygh
Important: If Ham 27 is marked
any injury or other 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Be ANNA ULLRICH RICHARD STUMPF 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21617 160 WILSON CLARK LANE, CENTREVILLE, MD. 19a. Informant's Name/Reletionship (Type, Print) CANDEE R. FIGIEL/DAUGHTER 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8/10/99 BALTIMORE, MD. OAK LAWN CEMETERY 21. Signeture of Funerei Service dicensee 22. Neme end Address of Fecility CHARLES S. ZEILER & SON, INC. MOOGRADO1 CONKLING ST. BALTIMORE, MD.21224 an 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only ona cause on each line. Approximete Intervat Between Onset and Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in daeth) /Medical Combolis monar Examiner Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or triury that initiated evants resulting in death) Last Dua to (or es e consequenca ot) physician the buria Physician/Medical Due to (or es e consequenca of) US0 as 1 been signed by the a should be detached i Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? myocardial infarction 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? cencyvic 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case reterred to medical axaminer? 26. Placa of Death (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 ☐ Yas 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 TYes 2 TNo 24 hours after death.

Funeral Director: A 2 ☐ Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) completely filled in by 4 ☐ Homicida Hospital 10 Certifying Physician: To the best of my knowledga, death occurred at tha tima, date and place, and due to tha cause(s) and mennar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. Medical 29a. Certifier (Check only one)

Box 68760. P.O. Records, Division of Vital

To the To the To the

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed causa of death (Item 20a) (Type, Print) OV Vau 31. Date filed (Month, Dey, Year)

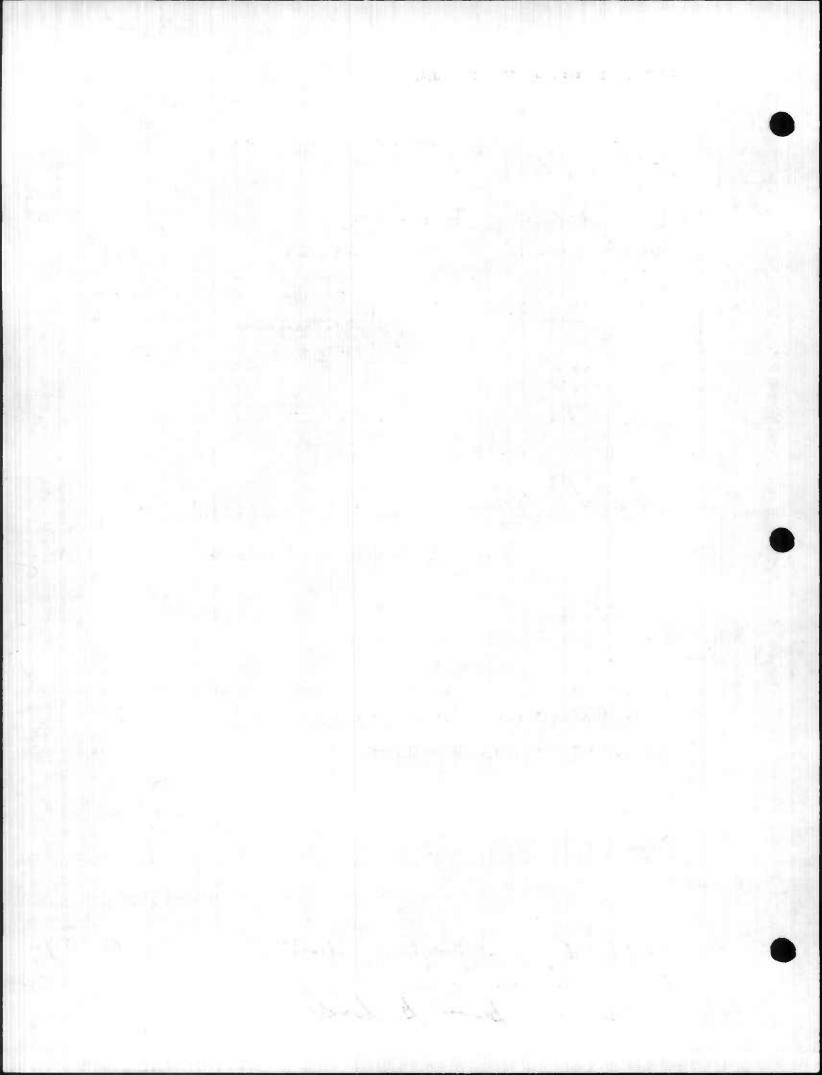
AUG 1 1 1999

32. Registrar's Signeture

22 S. GREEN ST. BALTIMORE, MD. 21201

29c. License number

29d. Date signed (Month, Day, Year)



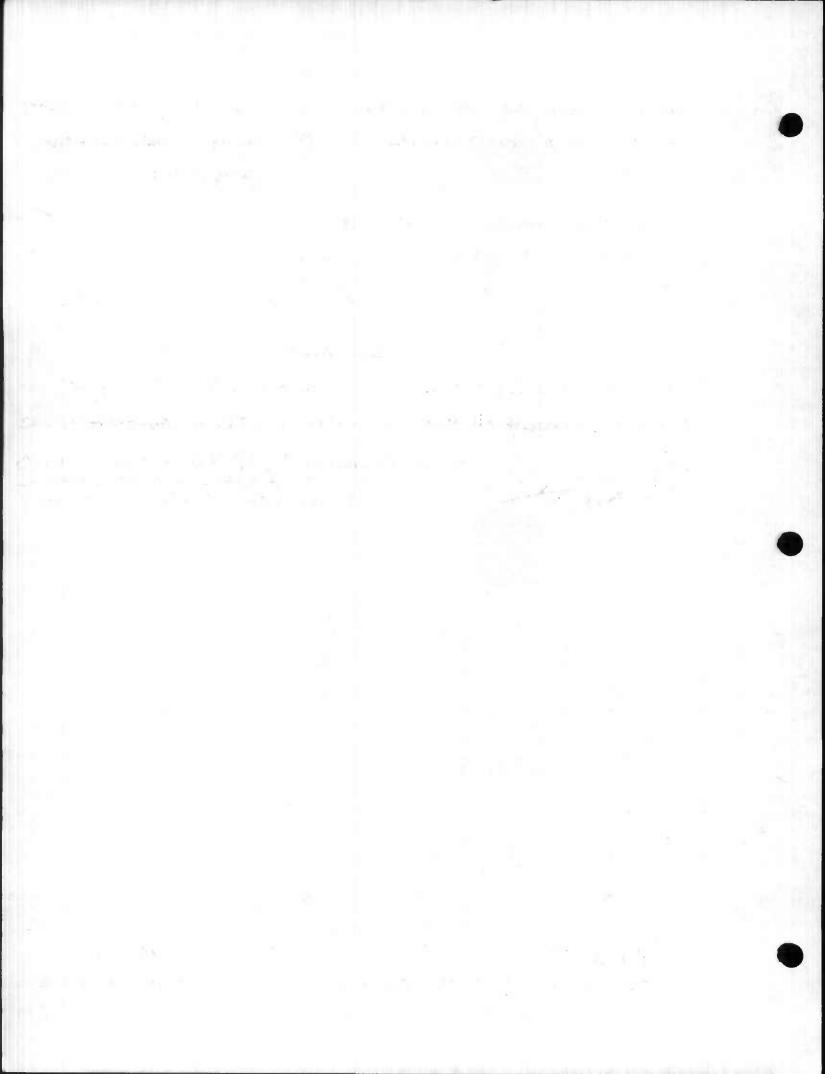
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** August GRACE ALEXANDRA Schae 1:50PM /Medical Ab. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner PASADENA LONG POINT ANNE ARUNDEZ ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 200 F Days Months Yrs. Director NONE uly 15, 1999 MARYLAND Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. The marked other than "natural", or items 23s or 28s4 show traumatic event, the Medical Esparainer may be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No PASADBNA Directo MARYLAND ANNE ARUNDEZ 10e. Street and Number 10g. Citizen of What Country? ROAD POINT 1581 USA LONG 21122 by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WhI +E 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT NONE 0 permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If itam 27 ia marked other any injury or other traumatic svant. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be PAUL CLOUSER J. Schaet BRIAN Deborah 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zio Code) 19a. Informent's Neme/Relationship (Type, Print) POINTROAD PASADENA MD 21122 1581 LONG hother Deborah Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removel from State Meadowridge Memoria Part 8/9/99 EIKridge, MARYLAND 4 Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility HUBBARD FUNBRAC HOME, Juc ure of Funeral Service Licensee 4107 WILICENSAVENUE - BAIT MORE, MD 21229

ter the mode of dying, such as cardiac or respiratory arrest,

Approximete interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** · CONGENITAL HEART DEFECT /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner TRISOMY or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): and Box 68760, attending physician for use as the buris Physician/Medical Due to (or as e consequence of): Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 8 Other (Specify) 1º this 28a. Date of Injury (Month, Day Year) 27. Manner of Death s after death. ii Director: After the ed in by the funera Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C completely filled 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) P40327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PASADONA, HD 21122 MD 8109 MARTA MARKMAN Ritchie HiGHWAY, 82. Registrar's Signature 31. Dete filed (Month, Dey, Year) State 1000 Registrar

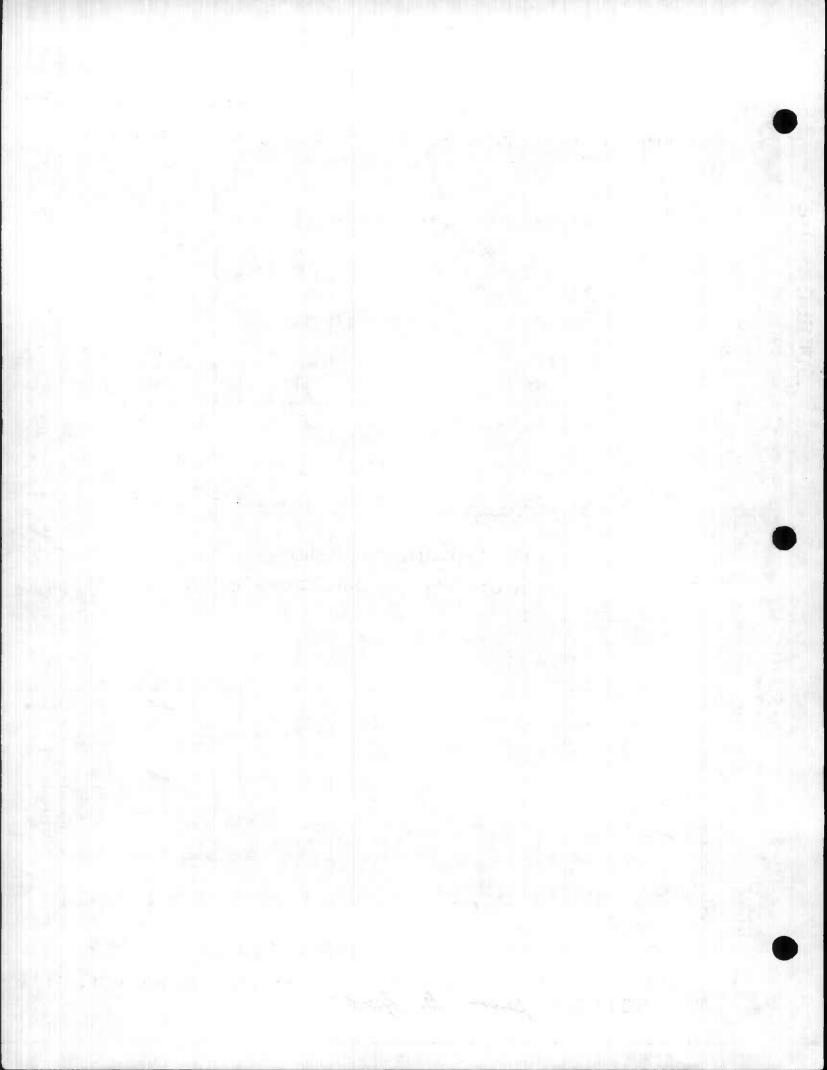
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	f Health and Mental Hygiene
Certificate of	of Death Reg. No.
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			Certificate of Death	Reg. No.	99 25236
Physician	Decedent's Name (First, Middle, Last)			2. Date of Death Month Day	3. Time of Death
/Medical	VUNE ST	EELE		AUGUST	7 1999 8:37 PM
Examiner	4a Facility Name (If not institution, give street				County of Death
<u> </u>	FRANKLINSBUARE				ALTIMORE
Funeral Director	5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last birth	rs. Months Days Hours Min	. (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Usual Residence of Decedent	21		MAY 7 19	10 R.I.
anylan show	10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
Cto Ma	Md BALTIMO	RE BA	LTIMORE Co.	Mc	1 ☐ Yes 2 No
vith the Marylar to or 28a-f show	10e. Street and Number		10f. Zip Code	10g. Citiz	zen of What Country?
	8823 JASPER		21234		USA
\$ 2 E 5	An	as Decedent Ever in U,S. med Forces?	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 		14. Race - American Indian, Bleck, White, atc.
by F		☐ Yes 2 ☑ No Yes, Give ear or Detes:	1 ☐ Yes 2 ☑ No Specify:	1 1 1 1 1 1	Specify: WHITE
	15. Decedent's Education	16a.	Decedent's Usual Occupation	16b. Kir	nd of Business/Industry
ed within 72 ho yglene. or then "netun rt, the Medical Completed	(Specify only highest grade comp	pleted) bllege (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	orking	
My Maria	12		BOOK KEEPER	15	EALESTATE CO
= 185 0	17. Father's Name (First, Middle, Last)		18. Mother's Ne	me (First, Middle, Maiden	Sumame)
Menta Menta arked To B	STANLEY PE		GRA		uwk)
2 sh end le m	19a. Informant's Neme/Retationship (Type, Pri	/	Mailing Address (Street and Number or R		/ /
Health Park	VANET COMMARA 20a. Method of Disposition	20h Place of	Dienocition (Name of	HAU. BAI	cation - City or Town, State
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emit. Pa Separtmen mportant: ny injury nce.	4 Donation 5 Other (Specify)	GREE	N MOUNT CREM	799 31	LTO. Md.
Departr Importa	21. Signature of Funerel Service Licensee				EAL HOME, CHTD.
	Galley Vale		7527 HARF	ORD Rd. B.	9LTO 14d 21234
	23a. Pert1. Enter the disease, or complication shock, or heart lailure. List only one cau	s that caused the death. Do no se on each line.	ot enter the mode of dying, such as cardia	c or respiretory errest,	Approximate Intervel Between Onset end Deeth
Physician /Medical	Immediate Cause (Finel	0 .	E 1.110		2/)
Examiner	disease or condition resulting in death) a.	Due to (or as a c	onary Edema		20 MINUTES
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rifficets be executed ng physicien and as the buriel-transit		Due to (or as a co			100////01
e and control of the	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury				1
liceta be i physicia a the bu	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):		7/2 7 7 7 7
The Day	d				
attendir for use					
The law requires that the deeth or stand stand been signed by the attend page 2 should be detached for us.	Part II. Other significant conditions contributing	ng to death but not resulting in	the underlying cause given in Pert I.		use contribute to the cause of death?
that the debag details				1 □ Yea ,24	No 3 Probably 4 Unknown
ulras tr signe id be d by				24a. Was an autop	sv 24b. Were autopsy findings
The law requirements been a page 2 should Completed				performed?	available prior to completion of cause
a has				4 🗆 Von 0 🗆	of death?
certificata rector, pag	25. Was case referred to medical		26 Please of De	1 ☐ Yes 24 eth (Check only one)	No 1 ☐ Yes 2 ☐ No
e cent direct	examiper? 1 Ves 2 No Hospita	II: 1 Inpatient 2 ER/Out	Other	Home 5□ Residence 6	□Other (Specify)
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tal or Attanding Physician: re after deeth. al Director: After this certificated in by the funeral director, Certification: To Be (3 Suicide 6 Could not ba 4 Homicide determined 28e	. Place of Injury - At home, fan building, etc. (Specify)	m, street, lectory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
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To the Hospital or Attanding Physician: The I within 24 hours after deeth. To the Funeral Director: After this centificate his completely filled in by the funeral director, page Medical Certification: To Se Com	29b. Signature and fille of certifier	nd manner stated.	29c. License number		
o t y t o o	250. Signatury and the cartiner	2.0			e signed (Month, Day, Year)
	Jenera	acce)	0005330		17/99
	30. Name and address of person who complete	d cause of death (Item 23a) (I	FRANKLINS BYARE	DONE BOLT	THINGE MA 21227
Chata	31. Date filed (Menth, Day, Year)	32. Registrar's Signature	THINKLING ON THE	DKIVE DHL	I'MUK L, MU ZIZO I
State Registrar	AUG 1 1 1999	sento.	Sparks		

State Registrar



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TAHEDL	Decedent's Name (First, Middle, La	qt)	Cel	rtificate of	Death	2. Dete of De	Reg. No.	- Can C	3. Time of Death	
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Funeral	5. Social Security Number 6. S	DW 005	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	v. Year)	Count	ece (State or Foreign	
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Ura atter death v at', or Nems 23s Examiner must		12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Wes Decedent of H f Yes, specify Cubs 1 Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	ck, White, e W]		
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- 5 - 10 L	Mrs. Ingrid Cha			atie Ct						
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lor Attentation after death	4 ☐ Homicide determined	building, etc. (Spec	Souts	eer, rectory, ornos		City or Tov	vn, Stete)		more co. Up	
Hospital 24 hours Funeral stely filled		ysician: To the best of my kn		occurred at the tir	ne, date and place	12				
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To the To the comple	29b. Signeture end title of certifier	- N		29c. Licens	e number		29d. Date signe	d (Month, I	Day, Year)	
1	Magnito ()	re Shule		0.0	.M.E.	P	UGUST 9	,1999		
H-1	30. Name and address of person who	completed cause of death (Ite	am 23a) (Type,			D-311			01001	
	31. Dete filed MORIM DEV. Yearloo	32. Registrar's Sign	nature	111 Penn	street,	Baltimo	ore, Mar	yLand	1 21201	
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aryle aryle				2		10d. inside City Limits 1 ☑ (es 2 ☐ No
No Page	119 /1//	1 13,	ALTIMO	12E	T	
5 8 3	10e. Street and Number	1 000-6	10f. Zip Code	2.0	10g. Citizen of W	hat Country?
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	11. Merital Status	12. Wes Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of If Yes, specify Cu	Hispanic Origin? (Specify ben, Mexican, Puerto Rica	Yes or No- In, etc.) 14. Race Bleck	- American Indien, , White, etc.
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2 0 0 0 0	19a. Informant's Neme/Raletionship (1-10-1	oute Number, City or Town, S	State, Zip Code)
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	/ /		03	10377	AU) 9,	99
	30. Name and address of person who		- 01	D	~ 4	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Vac **Physician** Am 2:36 ecil august 1999 Wilt /Medical 4b. City, Town, or Location of Beath 4a Facility Nama (If not institution, give street and number) 4c. County of Deeth Examiner 5401 Old Court Randalls town Baltimore Northwest Huspital Center If Under 24 Hrs. 8. Data of Birth Month, Day, SEP. 10, If Under 1 Year 9. Birthplace (Stele or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1927 Days 10M 20 F Months Hours 220-26-9654 71 Maryland **Director** Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County tam 27 is marked other than "natural", or itema 23s or 28a-f show other traumatic avant, the Medical Examinal must be notified at Director 1 Yes 2 No Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14 Third Avenue 21227 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiena. Important: If item 27 is merked other than "netural", or item any injury or other traumatic avent, the Medical Emirina. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white þ 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry rade completed) College (1-4or 5+) Elementary/Secondery (0-12) Turbine Mechanic BG&E 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Peter H. Wilt Ella Green 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Calvin Wilt - son 14 Third Avenue, Halethorpe, Md. 21227 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 8/12/99 1 X Burial 2 Cremetion 3 Removel from State Elkridge, Md. 4 □ Donetion 5 □ Other (Specify) Meadowridge Memorial Pk. 21. Signeture of Funerel Service Licenses 22. Name end Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · ANTERIDSCLEROLIC CHROIDVASCULAR DISEASE Examiner Due to (or as e consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-fran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760, thet initiated events resulting in death) Last Due to (or as a consequence of) 5 P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vitai Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy has 1□ Yes 25 No 1 ☐ Yes 200 No certificata To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2DER/Outpatient 3 DOA Medical Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end mennar as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29a Certifier 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifie 29c. License number 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

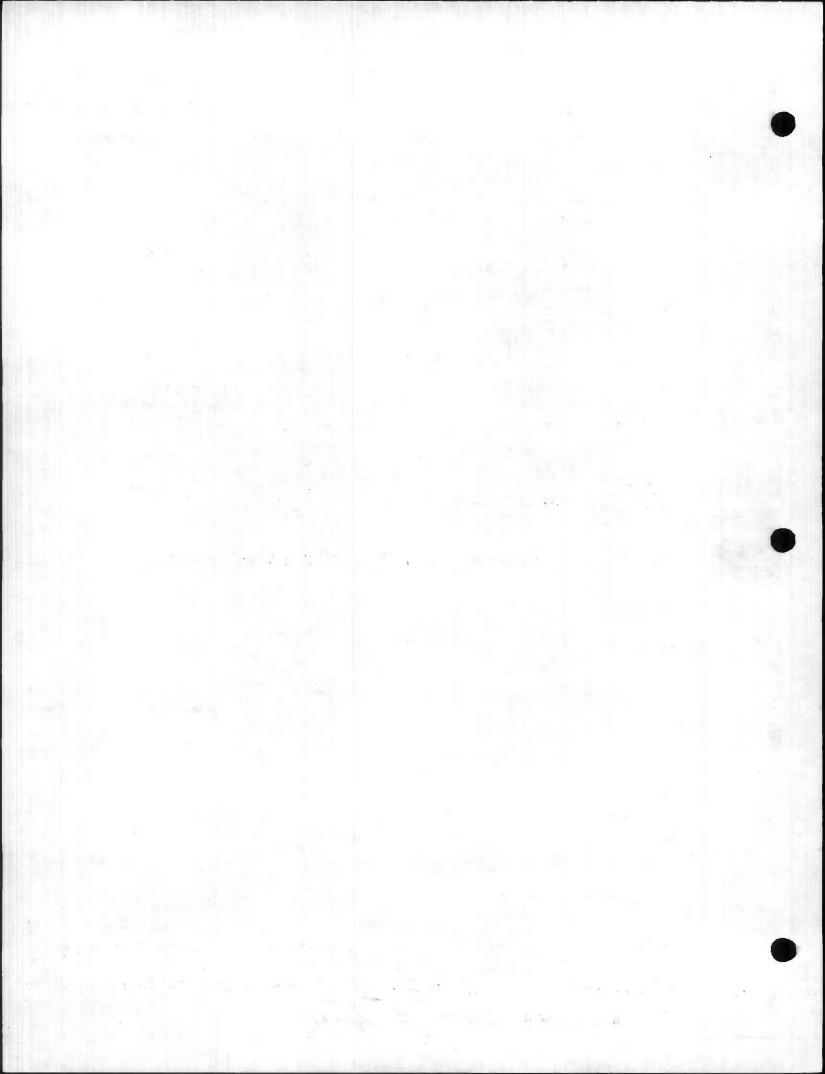
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32. Registrar's Signature

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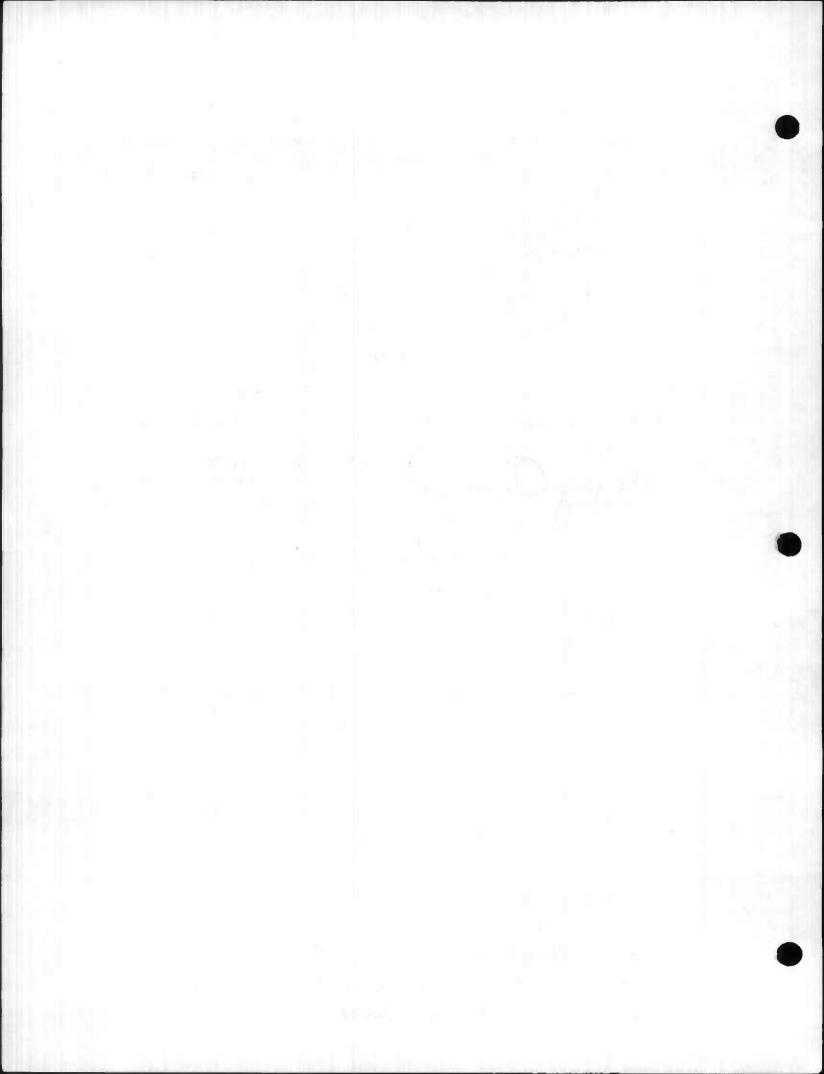
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Dey 1999 Month **Physician** Lucinda Wagner August 4, 6:25 PM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1450 Virginia Avenue Anne Arundel Severn Hours Min. 8. Deta of Birth Month, Day, Year) 7 / 17 / 1931 5. Social Security Number if Under 1 Yaer 9. Birthpleca (Stete or Foreign Country)
W. Virginia 7. Aga (In yrs. last birthday) **Funeral** Days 1□ M *\\F 235.52.6461 68 Yrs. Director Usuel Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits r 28a-f show 1 Yas 2 No Director Anne Arundel Severn with the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? must be n 1450 Virginia Avenue 21144 USA by Funeral 12. Was Decedent Ever in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. the Medical Examiner filed within 72 hours after 1 Never Merried 2XXMarried 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Yes 2 No Baltimore, Maryland 21215-0020 b Specify: White 3 ☐ Widowed 4 ☐ Divorcad 'natural' Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) 12 Produce Clerk Jermans IGA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hisnit: If Item 27 is marked oth lury or other traumstic even Be Jonah Justice Mary Hite 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William Wagner - Husband 1450 Virginia Avenue, Severn MD 21144 20b. Placa of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete ty Burial 2 □ Cramation 3 □ Removel from State 4 □ Donaţiop 5 □ Other (Specify) Department in Important: If any injury or Nichola-Bether U.M.C. 8/7/99 Odenton, MD meral Servica Licen 22. Name end Address of Fecility Fink Funeral Home, PA Kelly Gregory ink 426 Crain Hwy., SW, Glen Burnie, MD 21061 11. Enter the dis Approximete Intervel Between Onsat and Death Enter the distring of conplications that caused the death. Do not enter the mode of dylng, such as cardiec or respiratory errest, k, or heart failure. List hab one cause on each line. **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Carcinomalung with brain metastasis 3 years Examiner Due to (or es a consequenca of): Examiner Nonsmall cell carcinoma lung 3 years The law requires that the death certificate be executed the buriel-transit pue Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or es e consequenca of): Box 68760, attending physiciar Physician/Medical thet initieted events resulting in deeth) Lest Dua to (or es a consequenca of): USe as P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. be detached 23b. Did tobacco use contribute to the cause of death? signed by XYes 2 No 3 Probably 4 Unknown Division of Vital Records, ģ 24a. Was en eutopsy performed? 24b. Were eutopsy findings Completed Deed evailable prior to completion of cause of deeth? has page 2 certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home STResidenca 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Yeer) funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No within 24 hours efter deeth To the Funeral Director: 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide ***Cortifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, death occurred et the time, dete and pleca, and dua to the ceuse(s) end manner stated. 29a. Certifier Medicai completely (Check only Attending Physician 29c. Licensa number 29b. Signature end title of certifiar 29d. Data signed (Month, Day, Year) D44973 August 6, 1999 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Gurmeet S. Sawhney MD, 325 Hospital Drive #202, Glen Burnie, MD 21061 31. Dete filed (Month, Dey, Year) AUG 1 1 1999 32. Registrer's Signeture State oouts

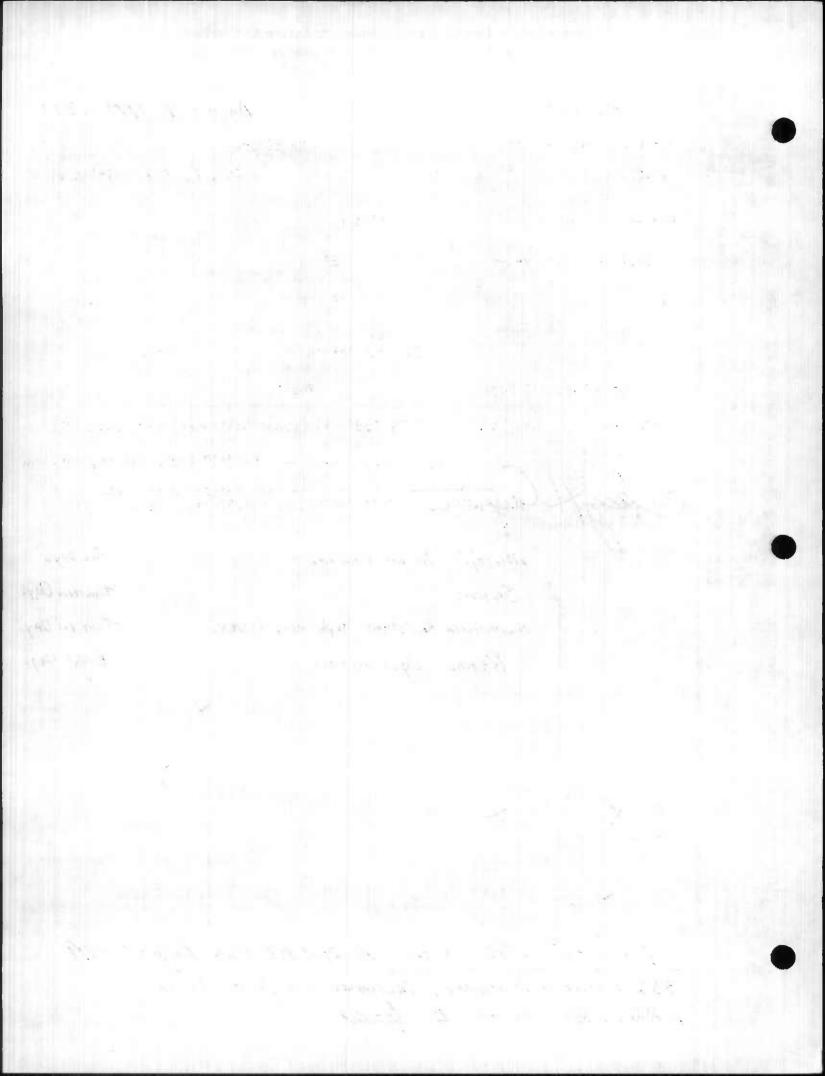
DHMH 16 Rev 6/95

Registrar



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	Examine		4a Facility Name (/	f not institution, gi	va street and number)				4b. City, Town, or	Location of Deat	4c. County	of Death	
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П	Funeral	Months Days Hours Min. (Month, Day, Year)								9. Birthpi	ace (State or Foreign ry)		
	Director	-	212-26-0 Usual Residence of)548		70	113.			Jan. 7	, 1929	Ba]t	imore, MD
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an	should be filed nd Mental Hygi marked other imatic event,	LOB	Franc	is Marsh	all Kevs				Thetta				
Maryland 21215-0020	should be nd Mental marked c	-	19e. Informant's Na			1	9b. Mailing Addre	ss (Street	and Number or R	ural Route Numb	er, City or Town,	State, Zip	Code)
	ges 1 and 2 should be filed within to f Haalth and Mental Hygiene. If Item 27 is marked other than or other traumatic event, the Mental than the file of the file		Sandra W	lood	Daughter		1452 Red	fern	Avenue	Baltimo	re Mary	land	21211
re,	of Had		20a. Method of Disp	position		20b. Place	of Disposition (N tery, cramatory or	ame of		Date	20c. Location -	City or To	wn, State
E	Pages nent of int: If its iry or o			☐ Cremetion 3 [5 ☐ Other (Speci	Removal from State		ar Grove			8/12/99	Cockeysy	ille	, Maryland
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death anek was 4b. City, Town, or Location of Death ity Name (If not institution, give street and number) BALTIHOR MAR If Under 24 Hra. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) Month, Day, Year) 10/9/1918 -01-80 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inalde City Limits N/A Baltimore 1€ Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 4505 Willshire Avenue 21206 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Waa Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 √Yes 2 No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Supervisor Computer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Phillip Wagner Mae Lydia Bacon 19a. tntormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Catherine Wagner/ Wife 4505 Willshire Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 8/9/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility John C. Miller Inc. eral Service Licenses 6415 Belair Road Baltimore, Maryland 21206 that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting In death) rmok Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? axes Unknown 1 Yas 2 No 3 Probably 24a. Was an autopsy 24b. Wera autopsy findings

Physician /Medical Examiner

Physician

/Medical

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sician and burial-transit physician at the burial Physician/Medical þ Completed Be this Certification: After To the Hospital or Attending | within 24 hours after death.

To the Funeral Director: After completely filled in by

Division of Vital Records, P.O. Box 68760.

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25. Was case ret	erred to medical	ical 26. Place of Death (Check only one)									
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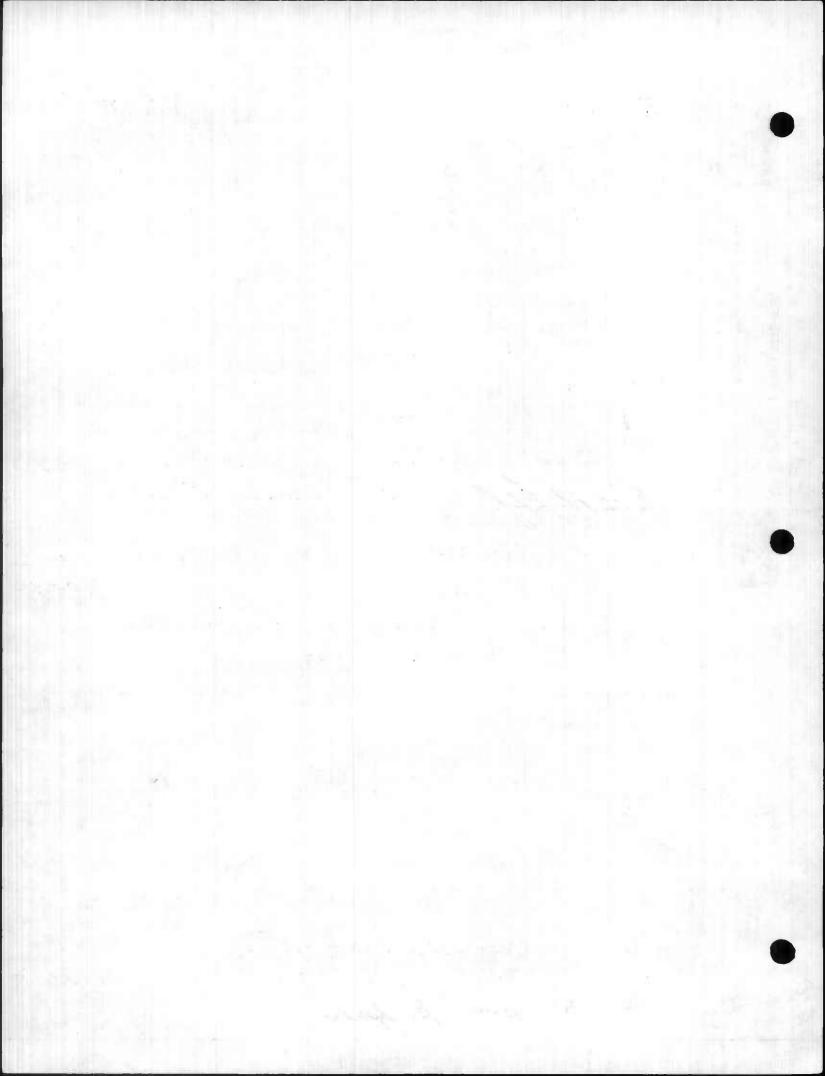
29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifie.

SKY-GOOD SAHARITAN HOSPITAL ORONE 32. Registrar's Signature

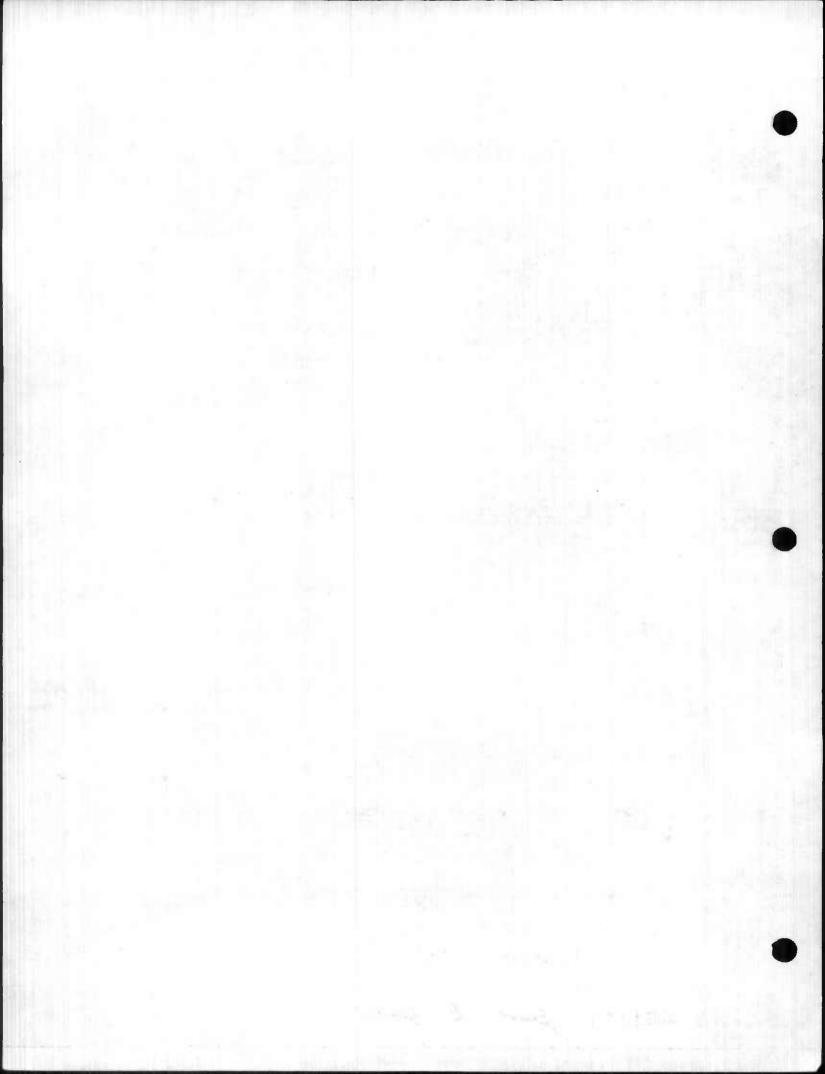
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State of Maryland / Department of Health and Mental Hygiene 9 25243

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedent's Nama /First, Middle, Last **Physician** AUGUST 10, 1999 6:15 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner 4001 OLD COURT ROAD #313 BALTIMORE BALTIMORE 8. Dafa of Birth (Month, Dey, Yaer) AUG. 2, 19 If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number Birthplaca (Stata or Foraign Country) 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 1□M 2♥F 70 Yrs. 215-22-1800 MD Director Usual Rasidance of Decedant with the Maryland 10a Steta 10b. Counts 10c. City. Town or Location 10d. Insida City Limits r 28a-f ahow MD BALTIMORE 1 Yas 2 No BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Counfry? r than "natural", or items 23a or the Medical Examiner must be 1 4001 OLD COURT ROAD #313 21208 U.S.A. Pages 1 and 2 should be filed within 72 hours effer death and of Health end Mental Hygiene.
If item 27 is marked other than "natural", or itema 23 Funeral 14. Race - American Indian. 12. Was Decedanf Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) Black, Whita, afc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantary/Secondary (0-12) Collega (1-4or 5+) OWNER BOUTIQUE 12 18. Mother's Name (First, Middle, Maiden Sumema) 17. Fether's Name (First, Middle, Last) Be RESNICK GOLDMAN BENJAMIN Η. DOROTHY 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) JESSE YORK / HUSBAND 4001 OLD COURT ROAD #313 - BALTIMORE, MD 21208 20b. Place of Disposition (Nama of cematary, cramatory or other place) Deta 20c. Location - City or Town, Stata 20a. Mathod of Disposition XX Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Department of Important: If it any injury or o 8/11/99 BALTIMORE, MD BALTIMORE HEBREW CEMETERY 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Intarval Batween Onsat and Death with. Do not antar the mode of dying, such as cardiac or respiratory arrest, Physician /Medical Immediate Cause (Final Examiner Examiner and-Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or injury physician ar the death certificate be exe cance Division of Vital Records, P.O. Box 68760. inc Physician/Medical that initiated evants rasulting in daath) Last 88 esn signed by the a d be deteched f 23b. Did tobacco uss contributs to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☑ Unknown g 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of ceuse of death? certificate hes t irector, page 2 s 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Menger of Deeth 28a. Date of Injury (Month, Day Yaar) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural
2 Accident Attending 5 Panding invastigation 1 ☐ Yes 2 ☐ No death. after deat Director: the Funeral Director of the fu 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 6 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical To the Fune completely f (Check only one) To the To the To the 29d. Data signed (Month, Day, Year) 29b. Signature and

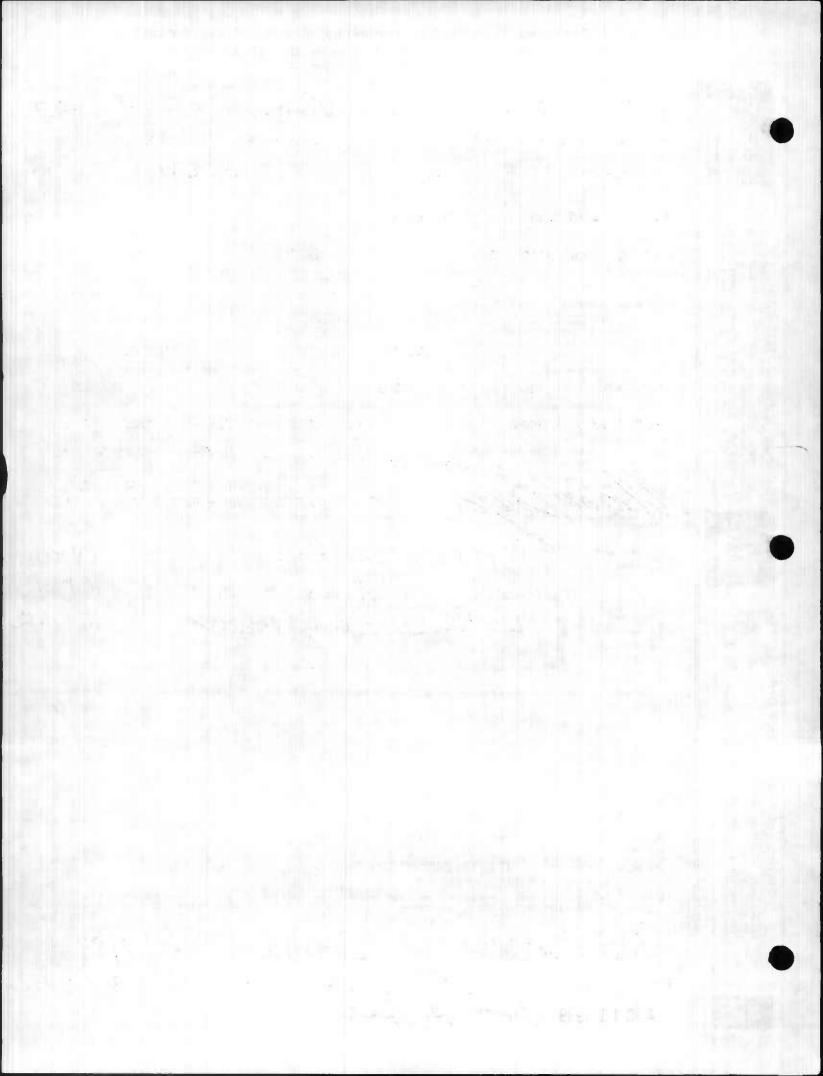
Registrar

30. Name and addrass of person who comp

AUG 1 1 1999

32. Registrar's Signatura

31. Data filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Day Yeer Month A.M S. 8:50 HAZEL JULY 241 ALGIRE 4b. City. Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Death HOWARD VANTAGE COLUMBIA HOUSE if Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months 10 M 22F 92 213-74-9993 VIRGINIA JULY 15, 907 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Maryland Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5400 Vantage Point Rd 21044 USA 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2 No Specify: White Specify: 3 ⊠ Widowed 4 □ Divorced Year or Detes: 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grade completed) 16b. Kind of Busineas/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Charles Shutters Emma Early 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Anne Leander, daughter 12202 Madeley Lane, Bowie, MD 20715 20b. Plece of Disposition (Name of camatary, cramatory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery 7/27 Hampstead, MD 21. Signeture of Funeral Service Liganous 22. Name and Address of Fecility Eline Funeral Home une 934 South Main St, Hampstead, MD 21074 23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Ceuse (Finel Panlum disease or condition resulting in death) Due to (or as a consequence of): premins Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 TYes 2 No 26. Place of Death (Chack only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10e. State

Funeral

Director

r then "natural", or items 23s or 28s-f show the Medical Examiner must be nothing at

permit. Pages 1 and 2 should be filed within 72 hours after a Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event, its lead and once.

altimore, Maryland 21215-0020

Director

Funeral

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Completed

death with the Maryland

pue physician s the burial attending the s been signed by the 2 should be deteched page . certificata director this funerel After death.

The law requires that the death certificate be executed

Box 68760.

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Records,

Division of Vital or Attending Physician:

after death Director: /

• Funeral Di Hospital

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Examiner Physician/Medical þ Completed Be 10 Certification:

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☐ 1000

27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident

6 Could not be 3 Sulcide 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated

28a. Date of injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

28c. injury et Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Moren Stere LHER Postrut

11055 31. Date filed (Month, Day, Year) 32. Registrar's Signature

28 1999

State Registrar

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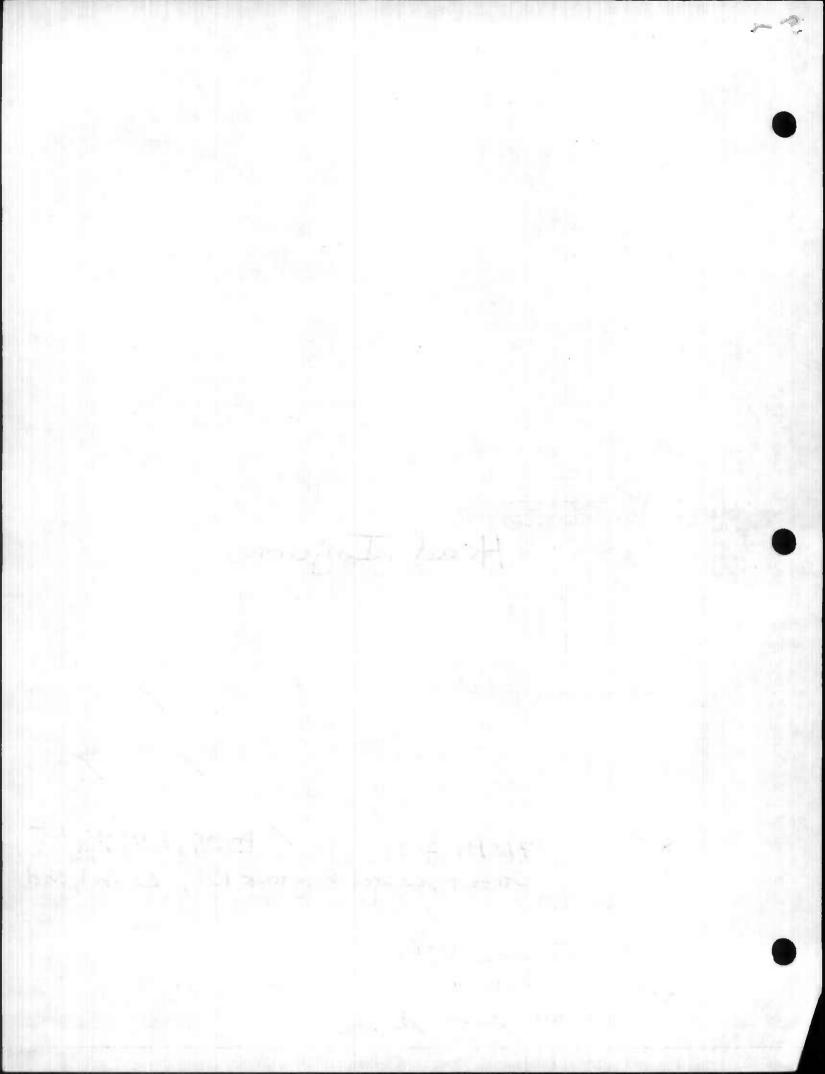
29a. Certifier

DHMH 16 Ray 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 26, per Phy. 7/28/99, Carroll County, wjl Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death July Peter Bodick **Physician** 24 1999 6:40am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 2225 Ridge Road Westminster Carroll 5. Social Security Number 044-22-9650 Birthplace (State or Foreign Country)

CT 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) July 31 1929 **Funeral** Deys 1 XM 2 □ F 69 Months Hours Director Usuet Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Merylan nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "naturel", or items 23a or 28a-f show ury or other traumatic svent, the Medical Examinat must be nother traumatic svent, the Medical Examinat Md Carroll Westminster 1 ☐ Yes 2 No Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 2225 Ridge Road 21157 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Marital Status Bleck. White, etc. Yes 2 No f Yes, Give 1950 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white 2 3 DWidowed 4 □ Divorced Year or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Kaiser Aluminum machinest 8 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be unknown Wing Jessie Ferguson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 1718 Arlington Ave., Relay, MD 21227 Jeffrey Bodick (son) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 X Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If any injury or once. Crest Lawn Memorial 7-27-99 Marriottsville, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel laige Haight P.O. Box 195 Sykesville, Md 21784 23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeti **Physician** /Medical Immediate Cause (Final month disease or condition resulting in death) Examiner Examiner and Il-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): attending physician a for use as the burial-Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence ot) signed by the aid be detached for Pert Ii. Other stgnfftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Aq 24b. Were eutopsy tindings evalleble prior to completion of cause of deeth? should Completed 24e. Wes en eutopsy certificate hes lirector, page 2 s 2 No 1 Yes 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, p Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 12 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as stated.

2 Medical Examtner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Height Med DINESH S. KALARIA Wash Loton

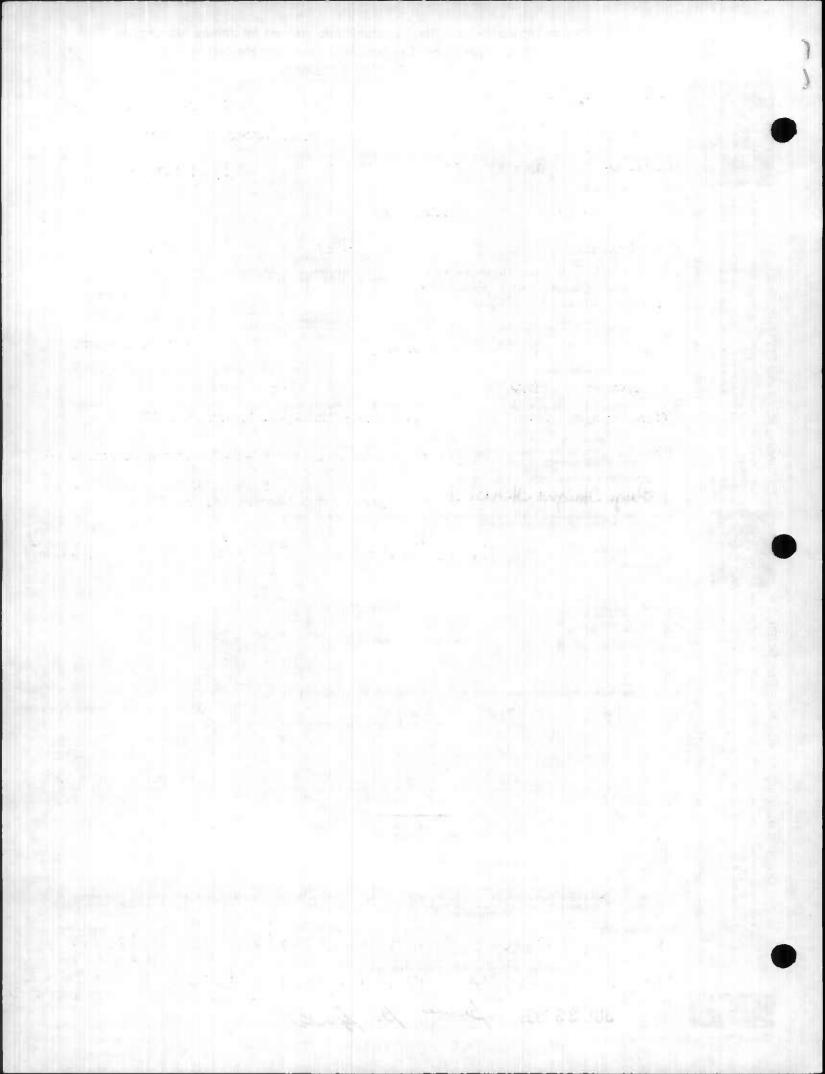
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Registrar

31. Dete filed (Month, Day, Year)

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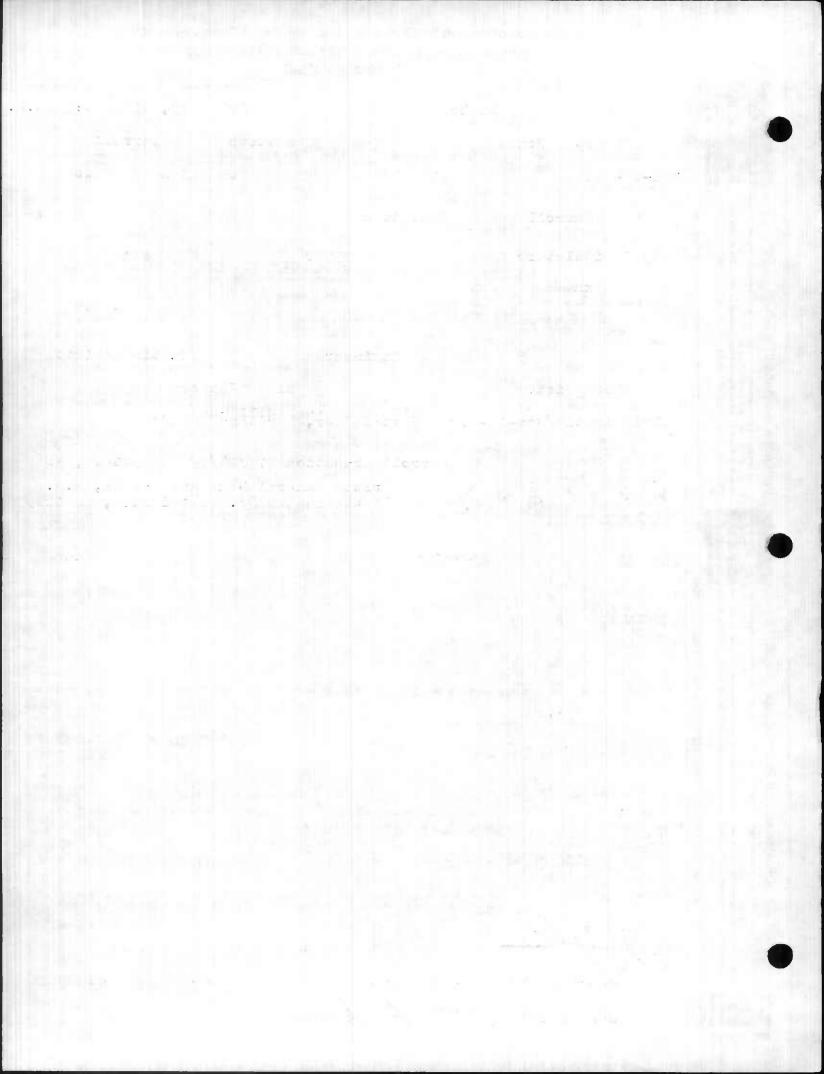
32. Registrar's Signature



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State of Maryland / Department of Health and Mental Hygiene

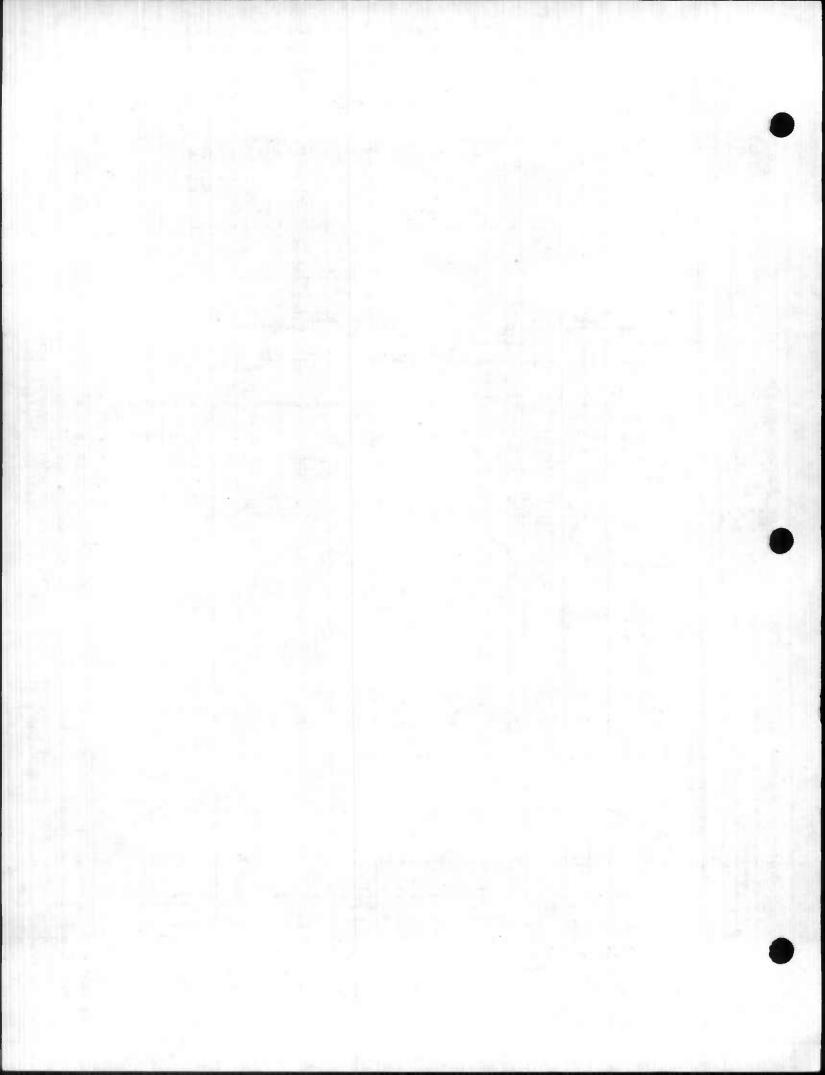
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г	Physicia	an	Decedent's Name (First, Middle, Last)							2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Was	rd	Bis	shop				July	25, 1	999	4:30 A.M.
	Examin		4a Facility Name (If	not institution, g	ive street and number	r)			4b. City, Town, or	Location of Deat	h 4c. County	of Death	
		Ш	Howards House 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1.						Taneyt	own		roll	
	Funeral		5. Social Security No			ige (In yrs. le	st birthday)	If Under 1 Yes Months Day			th av. Year)	9. Birthpla	ice (State or Foreign
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	ahov T		10a. State	10b. County	2.2		Town or Loc					100	d. tnalde City Ltmits 1 ☐ Yes 2 ☑ No
	filed within 72 hours after death with the Maryland Hybjach ther than "natural", or terms 23s or 28s-f show ent, the Moulcel Esphiner maint to motified	Director	MD	Carro) T T	Ta	neyto	wn					TI THE ZY NO
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	de a	Funeral	11. Maritat Status		12. Was Deceden Armed Forces	t Ever in U,S	3. 13. V	Vas Decedent o	f Hispanic Origin? (Suban, Mexicen, Puer	Specify Yes or No	14. Rac	e - American	
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Maryland 21215-0020	0 = 0 \$	Be (17. Father's Name (First, Middle, Las	st)				18. Mother's Na	me (First, Middle	, Maiden Sumam	10)	
/la	should be ad Mental marked o	70	Hub	er Bis	shop				Nina	Johns	son		
an	E DEE		19e. Informant's Na	me/Relationship	(Type, Print)		19b. Maitin	g Address (Stre	et end Number or R	ural Route Numb	er, City or Town,	State, Zip C	Code)
	DEN B		Melvin A	Austin	Son-in-I	aw	west	minste	et end Number or R augh Mi r, Mary	tandoas	1157		
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E.	/Medical xaminer		tmmediete Ceuse (Finet disease or condition resulting in death) Pneumonitis									1	week
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876	hysic the b	edical	that initiated events resulting in death) L		0.	Due to (or	as a consequ	uence of):					
Вох	ih ce	any			d							1	
H	ires that the death certif signed by the attending d be detached for use a	Physician/M	Part II. Other signifi	cant conditions	contributing to death	but not resul	lting in the ur	derlying cause	given in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
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	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the		one)		nd manner								
	within 2 To the comple	2	29b. Signature and	title offertifier				29c. Lice	ense number		29d. Date signe	d (Month, D	lay, Year)
			10	1.					D20330		07-26-	-99	
			30. Name and addre	of person wh	o completed ceuse of	deeth (Item	23e) (Type, I	Print)					
			John M	. Lehigi	h, M.D., P	.O. Bo	ox 111	0, 104	N. Main S	t., Unio	n Bridge	e, Md.	21791
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death Tronge Physician 7elug Broderick 12:45 PM /Medical 4a Eacility Nama (If not institution, give street and number) 4b. City, Town, or Logation of Death 4c. County of Death Examiner alcount 5 Gen (0. If Under 24 Hrs 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 6. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Months Director 24, 1929 218-26-6017 Maryland Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 28a-f show the Maryla must be notified at Maryland Baltimore 1 Nas 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or flems 23s or 400 Millington Ave. 21223 United States Funeral 12. Was Decedant Ever in U.S. Armed Forces? 1 ☐ Yas 270 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas XXNo Specify: Specify: White þ 3 ☐ Widowed 4 H Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiens. Wer than Elamantary/Secondery (0-12) Collega (1-4or 5+) 12 Prep Cook / Barmaid Foodservice permit. Pages 1 and 2 should be filled Department of Health and Mental Hygis Important: If Item 27 is marked other 17. Fathar's Neme (First, Middla, Last) 18 Mother's Name (First Middle Maiden Sumama) Be Charles Miller Jannie Rink 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) John Hauf P.O. Box 177 Broadway, New Jersey 20b. Place of Disposition (Neme of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State July 16 1 Burial 2 □ Cremation 3 □ Ramoval from State 6 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 1999 Baltimore, Maryland 22. Nama end Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funaral Sarvice Licensee N Vermy 4112 Old Columbia Pike Ellicott City, MD. 21043 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final Smunth diseasa or condition rasulting in death) Examiner Examiner PM burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last and Dua to (or as a consequence of) attending physician for use as the buria Box 68760. Physiclan/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu has 2 1100 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was casa rafarred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatiant 20 ER/Outpatient 3 DOA 26a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 26b. Time of 28c. Injury at Work? 5 Panding Invastigetion 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be 3 Suicide 26a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 26f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certify 29c. License number 29d. Data signed (Month, Day, Year) 6 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) Kel G 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Division of Vital Records, P.O. Box 68760,

10

State

Registrar

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(Check only one)

32. Ragistrar's Signatura

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30. Nema end address of person who complated causa of deeth (Item 23a) (Type, Print) 2301

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29c. Licensa number

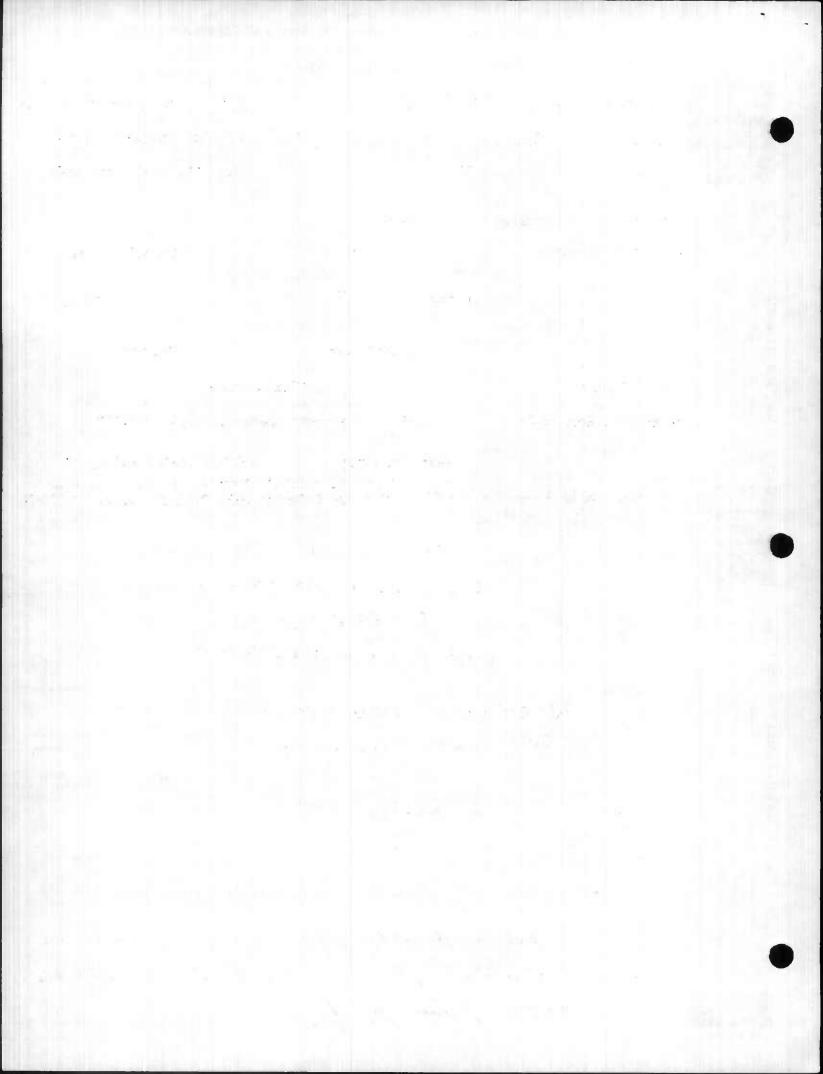
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29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Q

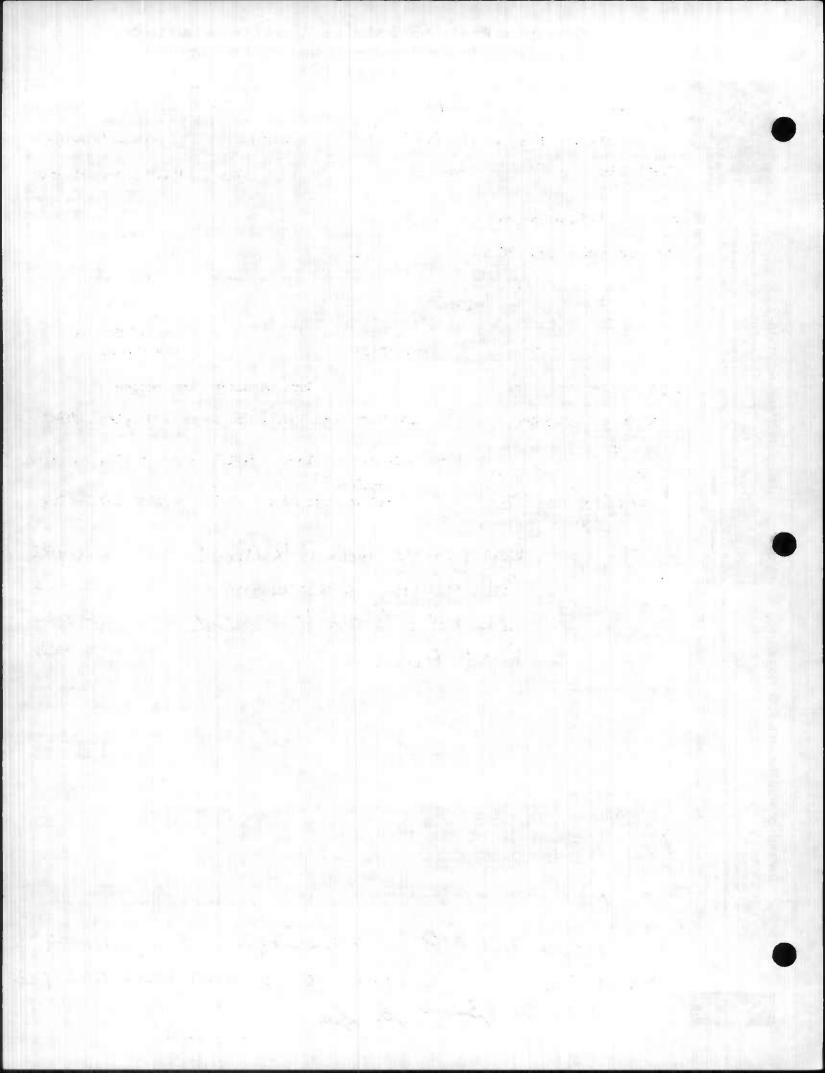
Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Cope Clyde July 4:10 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hospital Prince George's Regional -aure If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F Months Days 577-60-3638 Director Dec 7, 1920 Pennsylvania Usual Residenca of Decedent with the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 X Yas 2 □ No Directo MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #603 20707 200 Fort Meade Road USA permit. Pages 1 and 2 should be filed within 72 hours attar death 1 Department of Haelth and Mental Hydiana. Important: If item 27 is marked other than "natural", or items 23a enty Injury or other traumatic event, the Modred Examine mast obse. Funeral 12. Was Decedant Ever In U,S. Armed Forces? 1≦ Yes 2 □ No If Yes, Give Year or Datas: 1944 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marifal Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Induatry 15. Decedent's Education (Specify only highest grade completed) United States Elemantary/Secondary (0-12) College (1-4or 5+) 5+ Physician Government 17. Father'a Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Sara Geraldine Von Bergen Clyde Brewer Cope, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) /daughter 200 Fort Meade Rd. #805, Laurel, Maryland 20707 Carol Cope 20b. Place of Disposition (Nama of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 7/22/99 Catonsville, Maryland Metro Crematory, Inc. 22. Nama and Addrass of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707–4389

23a. Part1. Enter the district only one cause on each line.

Approximate

Approximate Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final DAKE disease or condition resulting in death) Examiner Examiner YRS physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Diseasa or injury that initiated evants resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medicai attending pl 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 20 No 3 Probably 4 Unknown signed t þ 24b. Were autopsy findings available prior to completion of ceuse of death? should ! Completed 24a. Was an autopsy performed? s cartificata has b director, paga 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: funaral director, Be 25. Was casa rafarrad to medice! examiner? 28. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residenca 8 Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of Aftar Natural 2 Accident 5 Panding 1 ☐ Yas 2 ☐ No daath. investigation after death Director: A 6 Could not be datarmined 3 Suicide 28e. Place of Injury - At home, farm, sfreef, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hour. the Funeral Direction 180 Certifying Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian edical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29d. Dafa signed (Month, Day, Year) 29c. Licensa number 29b. Signature and title of cartified THE MD 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 HAMILTON ST HYATBUILLE MD20782 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State JUL 2 2 1999

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Margaret Joan Cox JULL 20 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (II not institution, give street and number) 4c. County of Dea Examiner HOALTH CARE BALTIMORE AGNES None If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Yrs. 217-40-2367 Feb 6, Director West Virginia Usual Residence of Decedent 10a. Stafe 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or itema 23a or 28a-1 show event, the Medical Examiner must be notified at 1 ☐ Yes 20 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 급 9502 Westwood Drive 21042 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☑ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt.
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Important: If item 27 le marked oth
eny Injury or other treumatic even
bace. Be Ralph D. Keys Thelma F. Baldwin P 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9502 Westwood Drive Ellicott City, MD 21042 Walter Fred Cox Jr./Husband 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Gard 7-24-99 Marriottsville, MD 22 Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funerel Service Licensee Collins - With 0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximata Intervel Between Onset and Daeth **Physician** /Medical tmmediata Cause (Finel MENINGEAL CARCINOMATORIS 1 MONTH diseese or condition resulting In deeth) Examiner Examiner BREART MESTATIC and Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Couse (Disease or injury that initioted events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown signed by the 1 Yes 2 No 3 Probably Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Death

1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending ne Hospital or Attending n 24 hours after death. Ne Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

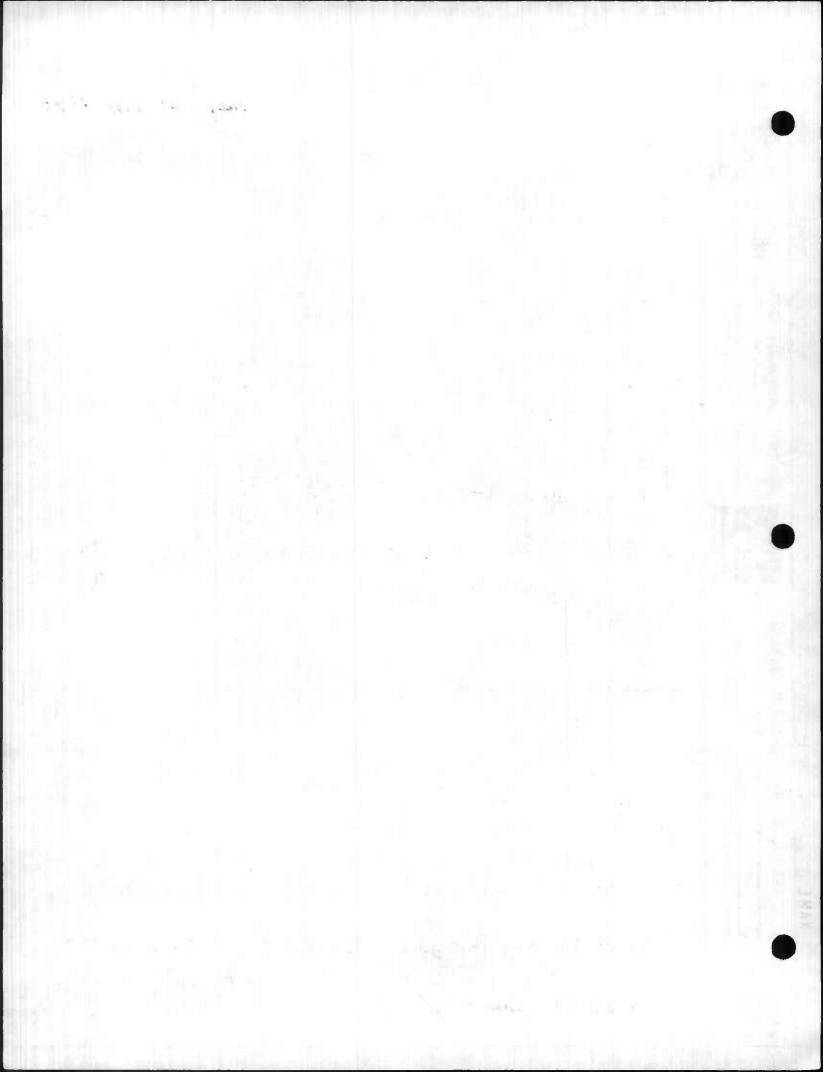
| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Attending Physician 30. Neme and address of person who completed cause of death (flem 23a) (Type, Print) 900 Centon Ave. Ballimore MD 21229 OSAFO (MD), St. Agnes Hos

Registrar DHMH 16 Rev 6/95

State

Cox, Margaret

AME

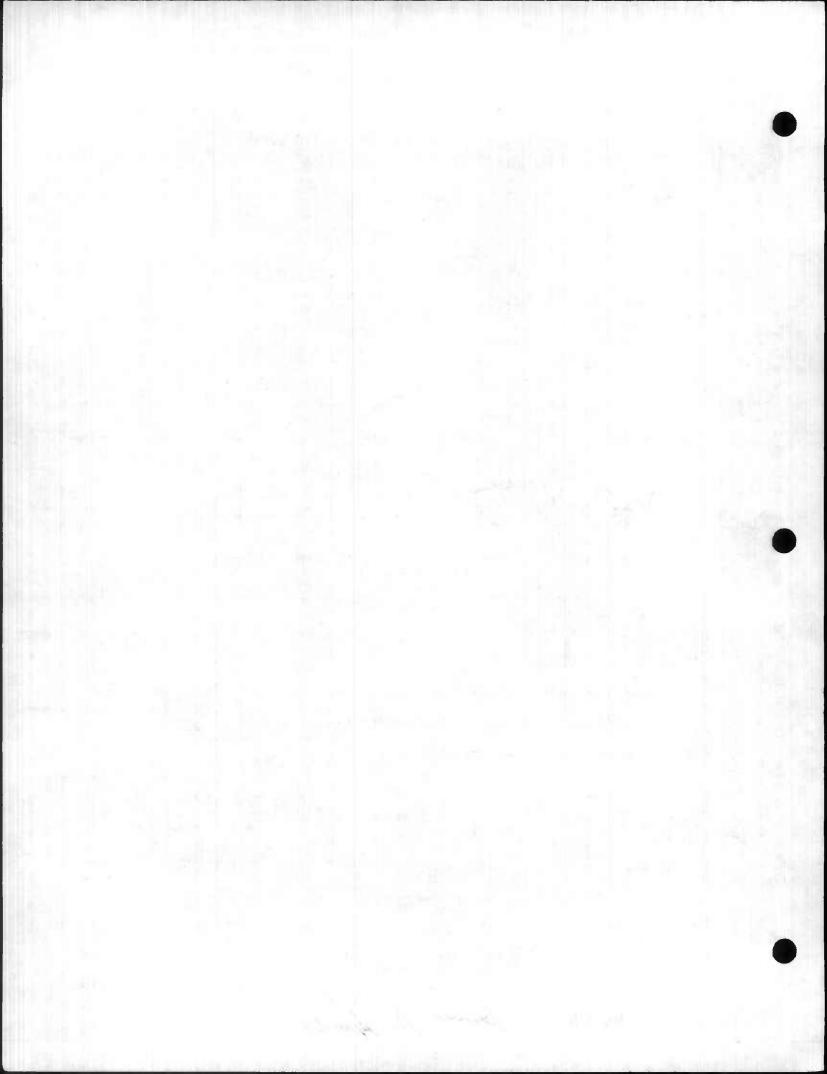


State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** AUBERTA LUCY DRUSMICH
4a Facility Name (If not institution, give street and number) 2 8 TUCY 1115 Am /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL LUTHERAN VILLAGE HEALTH CARE WESTMINSTER CARROLL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7/4/1914 Birthplace (State or Foreign Country) **Funeral** 1□M 2☑F Hours 167-05-7900 85 Director PENNSYLVANIA Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or flams 23s or 28s-f show edical Examiner must be notified at MD. CARROLL TANEYTOWN 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3907 OLD TANEYTOWN RD. 21787 USA. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, parmit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental hyglena.
Thorismit: if fem 27 is marked other than "natural", or her yinjury or other traumatic event, the Medical Empirical 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANDREW J. HUNGERMAN CATHERINE STUBENBORT 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 7 8 7 19a. Informant's Neme/Reletionship (Type, Print) MELISSA M. BATTEN -DAUGHTER 3907 OLD TANEYTOWN RD., TANEYTOWN, MD. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removel from State 4 Donation 5 Other (Specific NTOMBMENT QUEEN OF HEAVEN CEM . 8/9/99 PETERS TWP., PA. 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 ary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart larger. List only one cause on each line. Approximate Onset and Death **Physician** tmmediate Cause (Finel disease or condition resulting in death) /Medical GND STAGE ALZHUMEN DISEASE Examiner Due to (or as a consequence of): Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical Dua to (or as a consequence of): USA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown HYPORLUPIDEMIA GLAUCOMA þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed UNISTORY OF ETCH ABUSE paga 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funaral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b, Time of tnjury 28d. Describe how injury occurred 28c. Injury at Work? After Division or Attending 5 Pending investigation death. 1 Yas 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examines: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) acds W D48189 July 28 1999 JACOK M CONTING MS 30. Name and address of person who comple led cause of death (Item 23a) (Type, Print) 21158 JACOB 205 ST MARK m LEVING , M WOSTMINSTON 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

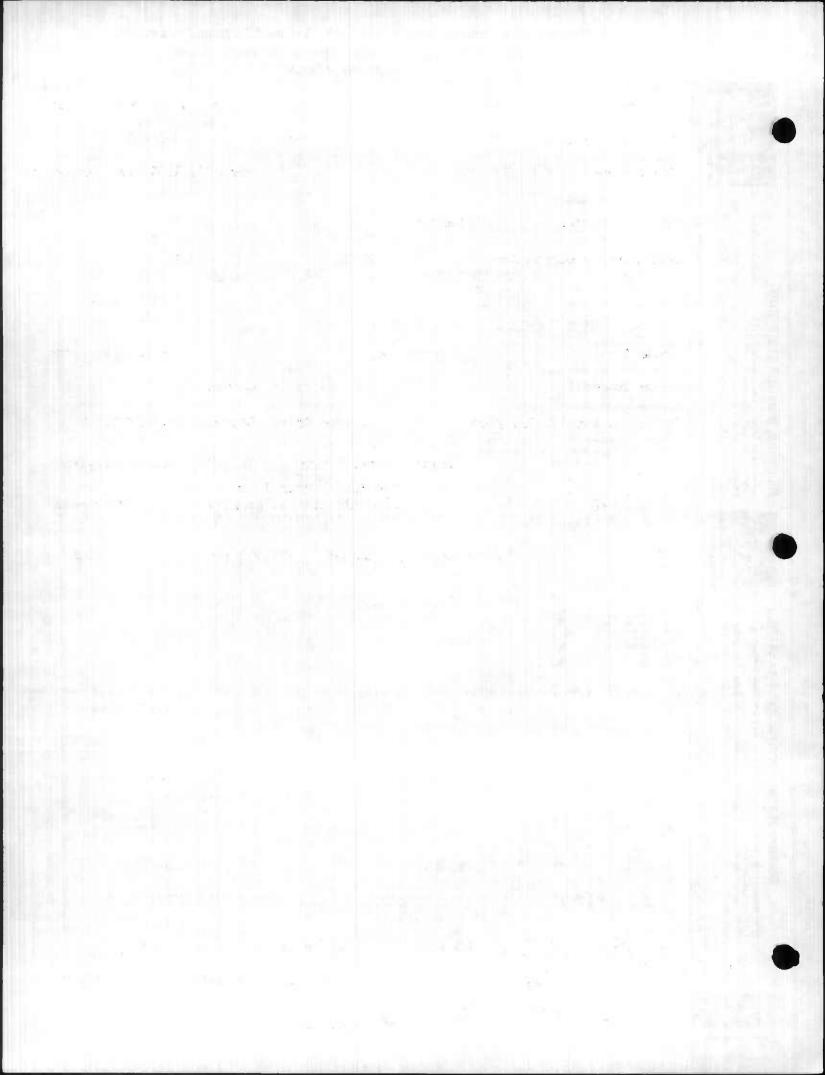
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State of Maryland / Department of Health and Mental Hygiene

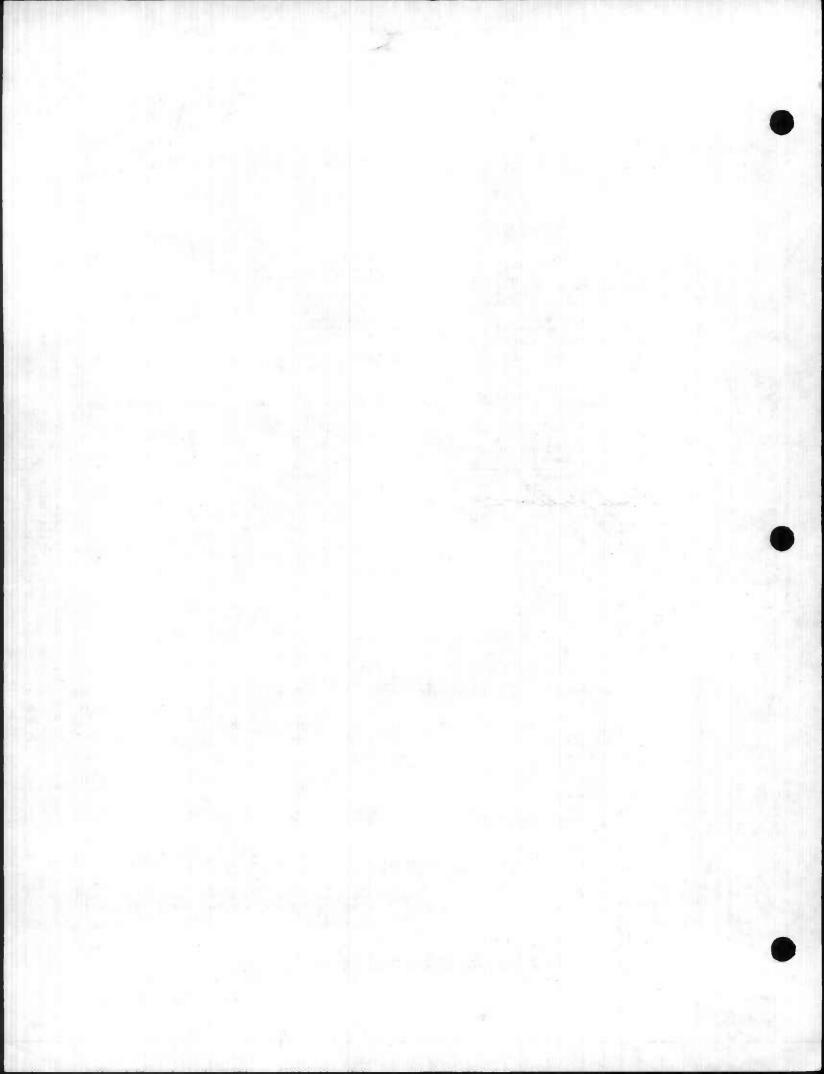
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State of Maryland / Department of Health and Mental Hygiene 9 25255

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/Medical Examiner	4a Facility Nama (If not institution, giva				4b. City, Town, or L	1 /	4c. County of		
Funeral	Livingston Health (5. Social Security Number 6. Se	x 7. Aga (In yrs.	last birthday)	If Under 1 Year	t. Washin	B. Data of Birth (Month, Day, Yo		Georges Birthplace (State or Foreign	
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and 2 Ballh B 27 i	Anthony P. Fusco/H				arbury Ro	ad, Marbu	ry, Mar	yland 20658	
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The law requires that the death certific cate has been signed by the attending p page 2 should be detached for use as Completed by Physician/Mec	14.1					24a. Was an a performed		24b. Were autopsy findings evailable prior to completion of causa of death?	
The page						1 ☐ Yas	2 0 No	1 ☐ Yas 2 ☐ No	
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To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. Medical Certification: To Be Com	1 SNatural 5 Pending invastigation 3 Suicida 6 Could not be	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injur Wor M 1 □	rk? Yas 2 No	28d. Describe how			
al or At a Direct of in by	4 Homicide datarmined	28a. Place of Injury - At he building, etc. (Specify	28f. Location (Stree City or Town, S	t and Number State)	or Rural Routa Number,				
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vithin To the compl	29b. Signeture and title of certifier Willia 7 Mm	ue un		29c. Licens	ce number	29d.	. 1	Month, Day, Year)	
	30. Name and address of person who co	mpleted causa of death (Item	701 LV	ingstan	R1. Ct.	WASHINGT	n Mo		
State Registrar	31. Date filed (Month, Day, Year) AUG 0 2 19	32. Registrar's Signa	ature 6	Loon	6.1	,			

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Vaa Green :50 27 1999 Herretta -12218 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Carroll County General Hospital Carroll Westminster | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Oct. 23, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 2\ F 86 1912 217-28-0882 Maryland Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21776 410 High St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementapy/Secondary (0-12) College (1-4or 5+) Factory Worker Shoe Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Harry Clabaugh Ivy Few 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Edward Green/son 305 Main St. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Buriaf 2 ☐ Cremetion 3 ☐ Removel from State 7/30/99 Linwood, Maryland 4 Donation 5 Dother (Specify) Pipe Creek Cemetery 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Perf 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Approximate tnterval Between Onsat and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Finat disease or condition resulting in death) da Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown

Physician /Medical **Examiner**

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been signed by the a

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certificate

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24 hours Hospital

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funeral director.

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Certification: To

Medical

or Attending Physician:

To the

The lew requires that the death certificate be executed

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Box

P.O. I

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Division

permit. Pages Department of Important: If it eny injury or o

Physician

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10a. State

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Pages 1 and 2 should be filed within 72 hours after death with the Menylen neat of Health and Mentel thygienn.
ant: if item 27 is marked other than "natural", or itema 23a or 28a-1 ahow ury or other thaumaite event, the Wedical Essentian manter morthed at ury or other thaumait event, the Wedical Essentian manter morthed at

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by

24b. Wera autopsy findings 24a. Wes an autopsy performed? evailable prior to completion of cause of death?

1 Yes 2 0 No 1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Yes 2 No 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Ave.,

Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, end due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

us of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial

2 9 1999

5 Pending investigation

6 ☐ Could not be

405 25

27 1899 Westminster, MD 2115/

1ala1 31. Date filed (Month, Day, Year)

25. Was case referred to medical

1 Yes 2 No

27. Manner of Deat

1 Natural 2 Accident

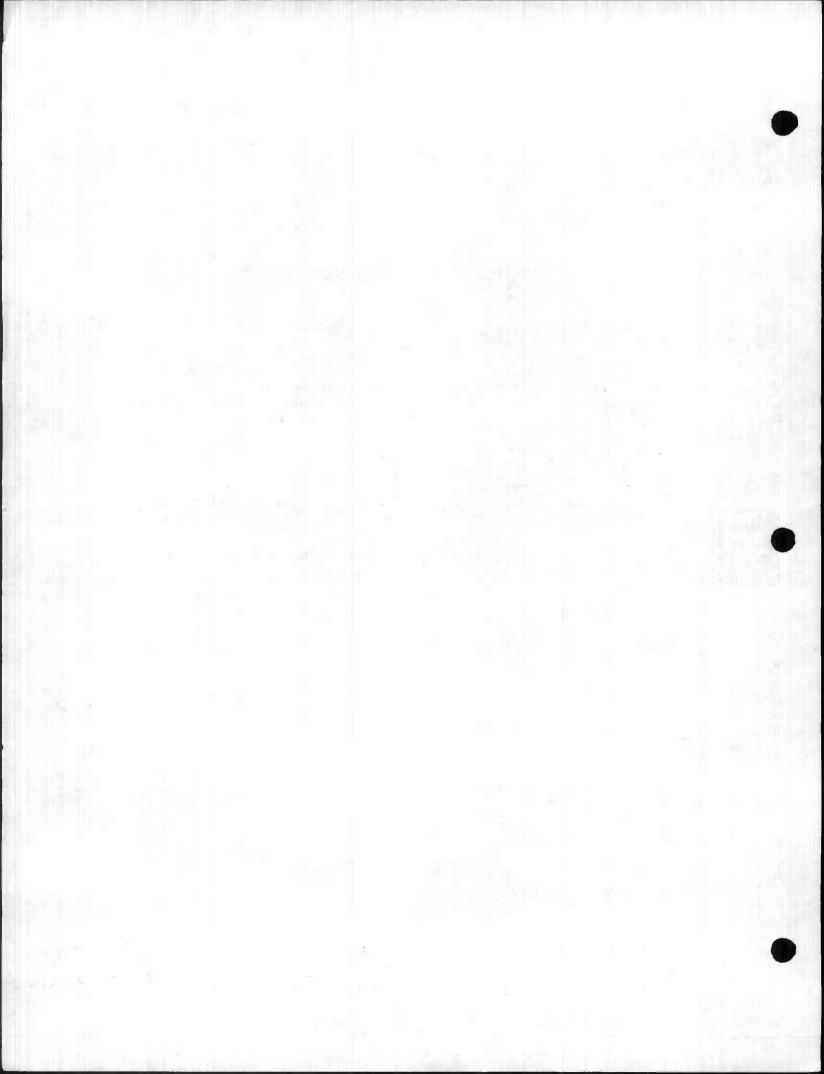
3 ☐ Suicide

4 Homicide

M 72. Registrar's Signature

Crwil

Registrar



ND ITEM:	5 PER F.H. G774 8-21-9			nt of Health and ate of Death		. No.	25251
Physician /Medical	1. Decedent's Nama (First, Middle, La	S S	GE.	MBE	2. Data of Death Month JULY	Day 31, /	Yaar 999 04:515
Examiner Funeral Director	163-30-6329	HOPKINS		Balti ler 1 Yaar If Under 24 Hr			
-f show fedan for	Usual Rasidence of Decedent 10a. State 10b. County	12	ity, Town or Location	Towns	hip		10d. Inside City Limits
ritems 23e or 28e-f show siner must be notified at Funeral Director	10e. Street and Number 6049 1/m/3	ECAN D	RIVE 101.2	17315	100	Citizen of Wi	nat Country? Amarican Indian.
Eramin by Fu	1 Never Married 2 Married 3 Wildowed 4 Divorced	Armed Forcas? 1 ☐ Yes 28 No If Yas, Give Year or Datas:	1 ☐ Yas	pedent of Hispanic Origin? (becify Cuban, Mexican, Pue 2 No Specify:		Specify:	Whita, atc. WHITE
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d Mental Hygi narked other matic event, To Be Co	17. Father's Nama (First, Middle, Last ARR 19a. Informant's Name Relationship	· GEMI		HELE		AFF	NER
nent of Health and ritt: If item 27 Ie r ivy or other traus	101 \m /	EMBE 20b.	6049 III	iss (Street and Number or F NDR/YND(iame of rother place), Gaspas Emscial Gaspas	TUR DOL	1er /7	17315Tity or Town, Stata
Departr Importa any inju	21. Signature of Fuheral Service Idea 23a. Part1 Enter the disease, or com- shock or heart failure. List only	1 August	тт	and Addrass of Facility Hartenste Second St ode of dying, Such as cardia	in Mortu	ary I	
ysician Medical aminer	shock or hand failure. List only Immediate Cause (Finel disease or condition resulting in death)	· MULTIPL	E ORGAN	SYSTEM			
n and lat-transit Examiner	Sequentially list conditions,	b. ADULT	or as a consequence of RESPIRA or as a consequence of	TORY DIST	iness Si	NOROM	= 2 weeks
the bur	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	,	or as a consequence of	•			3 weeks
cate has been signed by the attending p page 2 should be detached for use as Completed by Physician/Me	Part II. Other significant conditions of	d. LIVER				acco use cont	ribute to the cause of death?
should be detach							3 Probably 4 Vinknow
has been ge 2 should mpleted			-		248. Was an performe	d?	24b. Wara autopsy findings available prior to completion of cause of death?
rector Be	25. Was case referred to medical axaminer?	Hospitel: 1 Vinpatient 2	ER/Outpatient 3 1	Other	1 Yas eth (Check only one) Homa 5 Rasiden		1 ☐ Yes 2 ੴ No
within 2 to the Furneral Director. After this completely filled in by the funeral di Medical Certification: To	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide	28a. Data of Injury (Month, Day Year)	28d. Describe how	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Cartifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my knowniner: On the basis of examinorand manner stated.	owledge, deeth occurre etion and/or invastigation	d et the time, date end plac on, in my opinion, deeth occ	e, end dua to the cau urred et the time, date	se(s) and man e end place, ar	nar as stated. nd due to the cause(s)
Fun letely				9c. License number	290	. Data signed	(Month Day Year)
To the Fune completely file	29b. Signature and title of certifier	n Mo	2	RES-00			

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** JR HANLON, COLE FLORES 8 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 450-54-4631 1**⊠** M 2□ F 59 Texas Director Usuel Residence of Decedent with the Meryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits rel', or items 23a or 28a-f show Examiner owest be notified at MD Washington Hagerstown 1 WYes 2 No Director 10f. Zip Code 10e. Streef and Number 10g. Citizen of Whet Country? 17908 Clubhouse Drive 21740 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours efter death v. Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or Items 23s any injury or other treumstic event, the Medical Examiner must Funeral 12. Wes Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Rece - American Indian, Black, White, etc. 1 Yes 2 □ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Chevy Chase Bank Elementery/Secondery (0-12) College (1-4or 5+) ATM Coordinator Laurel, MD 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Cole F. Hanlon, Lillian Flores 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Karen Hanlon - Wife 17908 Clubhouse Dr., Hagerstown, MD 21740 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State Rocky Gap Cemetery 8-9-99 Cumberland, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Means 22. Name and Address of Fecility Hunter-Anderson Funeral Home 106 S. Mercer Street, Berkeley Springs, WV and. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, index, or heart feiture. List only one cause on each line. **Physician** SEPTICEMIA /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner MYELO DYS PLASTIC SYNDROME 8 MONTHS Examiner sician and buriel-transit the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury fhet initiated events resulting in deeth) Lest physician the buriel Box 68760. Physician/Medical Due to (or es e consequenca of) 9SU Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 K No 1 ☐ Yes 2 ☐ No Viital Hospital or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To of 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After 1 Neturei 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigetion within 24 hours after deet To the Funeral Director: completely filled in by the 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, sfreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29e. Certifier Medical 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. License number D53634 8-4-99 MD 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) IIIIO MEDICAL CAMPUS RD # 107 MATTHEW G. BECKW 1TH HAGERSTOWN MD 21742 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar AUG 11

DHMH 16 Ray 6/95

NAME: HANLON, COLE FLORES JR 12/31/1939 59 / M

DOS: 07/29/1999 RIGGLE,MARTHA A.







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 2 5 2 5 9

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Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental hygiene. Important: if item 27 is marked other than "natural", or may jollury or other traumatic svent, the Medical Example. To Be Completed by F	20a. Method of Di		☐Removal from Sta	CE	laca of Disposit ametery, crema	tory or other pla		Dete	20c. Location		
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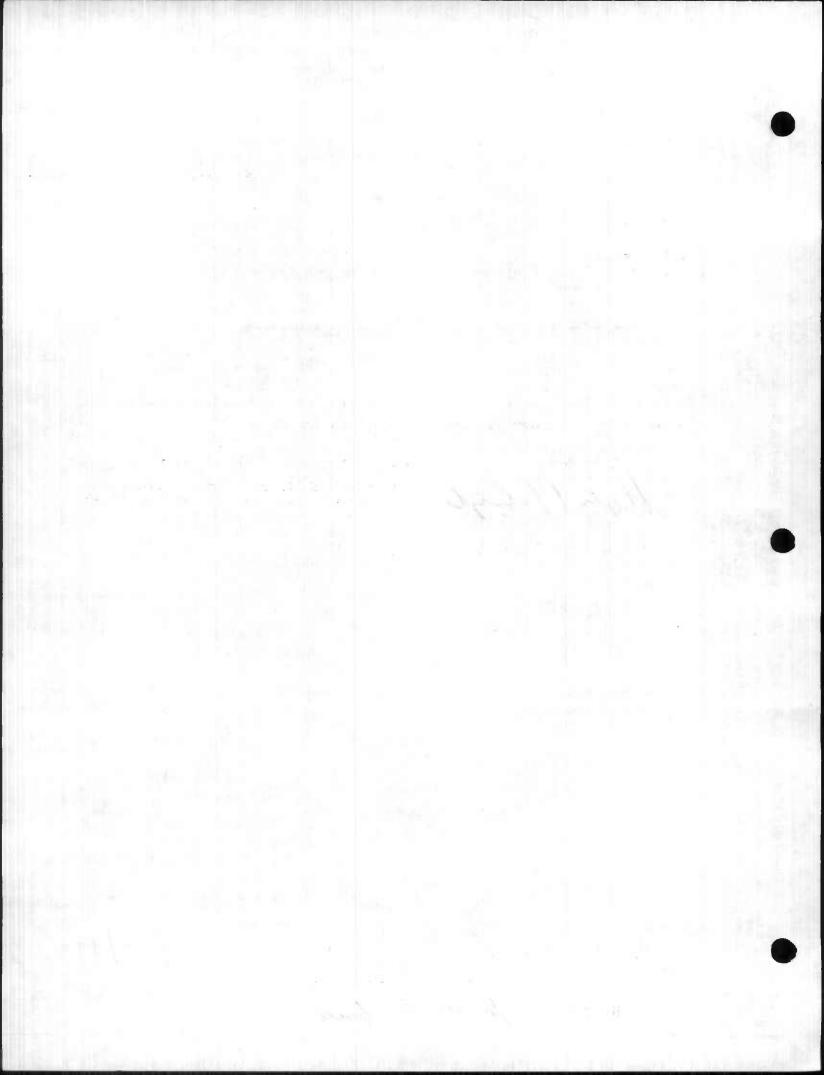
Registrar

32. Registrar's Signeture

31. Date filed (Month, Day, Year) G. Spark

State of Maryland / Department of Health and Mental Hygiene

							Certifica	ite oi	Death		,	Reg. No. 9	2	52	60
		1. Decedent's Nam	e (First, Middle	, Last)			TEU				2. Date of Dea Month	th Day	Year	3. Tim	a of Death
Physic /Med		Ethel Fay	y Hurle	V							July		999	2:	14 AM
Exam				, give street and nun	nber)				4b. City, Ton	wn, or Loc	cation of Death	4c. County	of Death		
		Easton	Memor	ial Hosp	oital				East	ton		Ta	lbot		
Funera	1	5. Social Security N	lumber		7. Age (In yrs.	last birtl	rugy/	er 1 Yea		24 Hrs. Min.	8. Date of Birt	h Vonel	9. Birthp	lace (Sta	ate or Foreign
Directo		245-90-7912 1 M 2 F 88 Yrs. Months Days Hours Min. (Month, Day, Year)											olina		
2		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location													
how my		10a. State	10b. County		10c. Cf	ly, Town	or Location						1		le City Limits
M	cs	Maryland	Caroli	ne	Gre	ensl	oro							LAJ	Yes 2□No
5 6	Director	10e. Street and Nu	mber				10f. 2	ip Code			1	10g. Citizen of	What Cour	itry?	
23a															
8 85	Funerai	11. Marital Status		Armed For	dent Ever in U	,S.	13. Was Dec	edent of	Hispanic Original Hispanic Original	gin? (Spec	cify Yes or No- tican, etc.)	14. Rac Bla	ck, White,		n,
d 21215-0020 Illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or frems 23a or 28e-1 ahow mt, the Market Earth at mat be notified at	F	1 Never Marr	_	ed 1 Tes	2X) No		1□ Yes						w Whi		
15-0020 72 hours aft	d by	3 Widowed	4 Divorced	Year or Da	ates:										
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21215-0020 d within 72 hours at glene. or than "natural", or or then "natural", or	id II	Elementary/Seco	ondary (0-12)	College (1	College (1-4or 5+)				190)						
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E REP	8	17. Father's Name		uist)								Malueri Surner	ne)		
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altimore, mlt. Pages 1 ar partment of Hea portant: If Hean's y Injury or other		20a. Method of Dis		3 Removal from 5		cemeter)	, crematory o	other p	lace)	l t	Data	20c. Location	- City or 10	wn, Stat	
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		21. Signature of F	neral Service I	icensee			22. Name	and Add	ress of Facilit	nhai	n Fune:	ral Hom	о РА		
m ades	1	11	1.h	Plu	ul							aryland		39	
		23a. Parti. Enter i	he disease, or	complications that conty one cause on a	aused the deet	th. Do n								Approx	imate Between
Physician				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									1		and Death
/Medica		Immediate Cause disease or condition	(Final	Meta	bolic	Ac:	idosis	5						24	Hrs.
Examine		resulting in death)		8.	Due to (c	or as a c	onsequence o	f):							
	è			Hypo	volem		- '							24	Hrs.
oute bu	Examiner	Sequentially list co	nditions	b. 11/100			onsequence o	f):							
0 2 2		Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying	Macc	ive G	20+	rointe	c+i	nal B	21000	4			21	Hrs.
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2 0 4		resulting in death)	Last										1		
.O. Box (the death certif the attending the attending	Physician/M			d											
d for an or	100	Part It, Other signif	ficant conditio	ns contributing to de	eth but not res	ulting in	the underlying	cause (given in Part t	<u>. </u>	23b. Did 1	obacco usa co	ecco use contribute to the cause of death		
ds, P.O. I	t y										10	Yes 2 No	3 Pro	bably	4 Unknown
odet deta	Бу Р	Cardiac	Arrn	ythmia								7			
Records, P ne law requires that a has been signed b age 2 should be dete	B	Toft W	ntria	alaw II.m	oxtxo	nh					24a. Was	an autopsy	24b. W	ere auto	psy findings
w require	i e	Tell A	entric	ular Hyp	ertro	рпу				_	perio	rmed?	co	mpletion death?	of cause
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- 2 00	. To	27. Manner of Deal		28a. Date (ER/Out		_		-		tence 6 Ott		<i>y)</i>	
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Division or Attending after death. Director: After Jin by the fune	Ca	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could r	ot be 200 Place	of Injury - At h	ome for			1100		Rf Location /	Street and Num	her or Ruc	al Route	Number
Or A Para	T.	4 Homicide	determ	ned buildir	ng, etc. (Specia	fy)	iii, sti oo t, tace	ory, onio			City or Tox				,
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Division or the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After thi compisately filled in by the funeral	Med										Dav. Ye	er)			
F.≱₽.8	-	Lou. Signature and	M // //									29d. Date signed (Month), Day, Year)			
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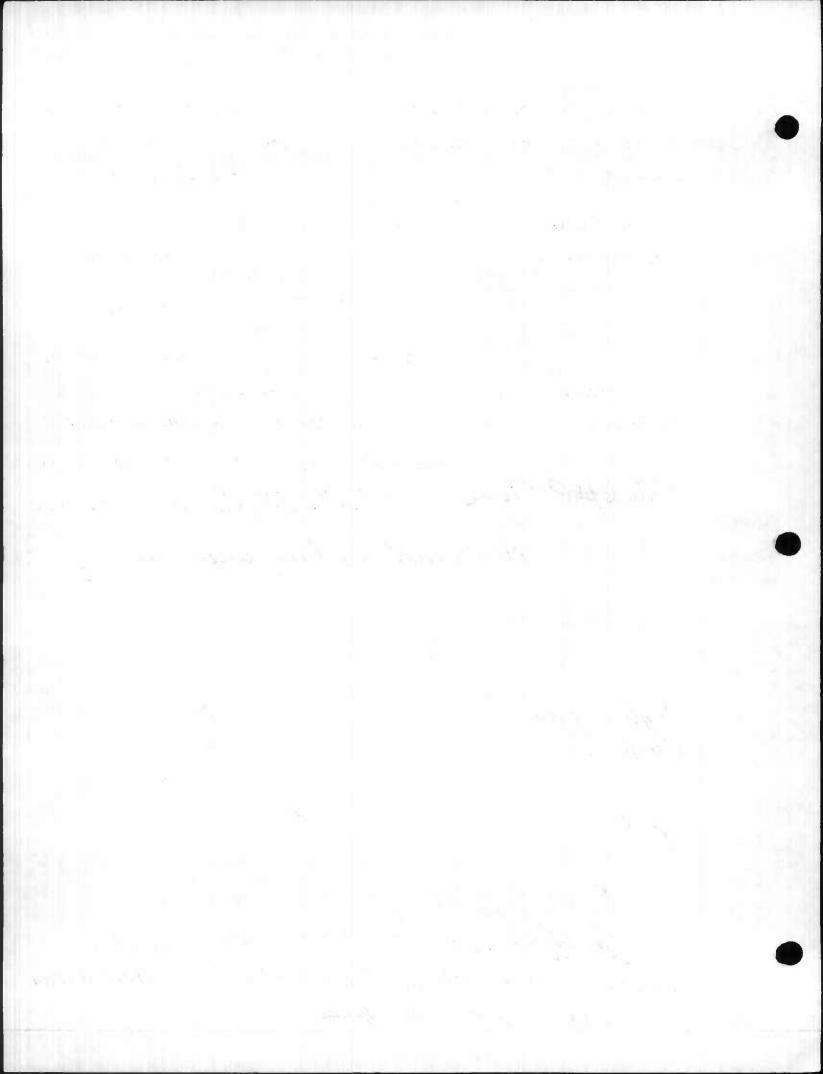
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name /First Middle 1 ast. 2. Dete of Deeth 3. Time of Death Month **Physician** Year Hickman Mervin Herman July 1999 11:15 AM /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Shore Nursing & Rehabilitation Center Caroline Denton If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** IXIM 2□ F Deys Director 218-14-4287 October 14,1922 Maryland Usuel Residence of Deceden with the Meryland Pages 1 and 2 should be filed within 72 hours after death with the Menylen nest of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show into the trainmatte event, the Medical Examinating manths not privated. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□ Yes 2₽ No Funeral Director Maryland Caroline Greensboro 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 26170 Boyce Mill Road 21639 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Poultry Processing 11 Line worker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Sarah VanSant Herman Hickman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mervin Bell Son 26170 Boyce Mill Road, Greensboro, Maryland 21639 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete permit. Pages Department of Important: If It any Injury or o Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Greensboro Cemetery 7/30 Greensboro, Maryland 21. Signalu 22. Name end Address of Fecility Moore Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest. **Physician** I-cell lung carunama Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner hysician end the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): 80 957 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. by Completed 24b. Were eutopsy findings 24e. Wes en eutopsy evailable prior to completion of cause of deeth? has eged 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Surring Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpetient 3 DOA this 27. Manner of Death 1 A Naturel 28c. Injury et Work? 28d. Describe how Injury occurred After Division 5 Pending investigation within 24 hours efter death. To the Funeral Director: A ✓ Accident 1 Yes 2 No thef 6 Could not be 3 ☐ Suicide Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

Image: Madical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completely (Check only one) 29c. License number 35284 29b. Signeture end title of-certifier 29d. Date signed (Month, Day, Year) . Washington St Eastonmd 2/601 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

JUL 28 1777



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JULY 27 Velmer J. Hamrick 8:00am /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Montha Days Hours 1X M 2□ F 232-50-8852 Director Sept 12, 1933 West Virginia Usual Residence of Decedent the Maryland 10e. State 10c. City. Town or Location 10b. County 10d. inside City Limits Nem 27 is marked other than "natural", or Nema 23a or 28a-f show other traumatic event, the Medical Examinar must be routed at 1 ☐ Yes 2 No Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? death with 4489 Centennial Lane 21042 United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuban, Mexican, Puarto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after or ant of Health and Mental Hygiene. natt of Health and Mental Hygiene. 1X Yes 2 No 1 Never Married 28 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify. þ If Yes, Give Year or Dates: 1954–58 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Coilage (1-4or 5+) Elamantary/Secondary (0-12) Supply Clerk Applied Physics Lab 18. Mother's Nama (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middla, Last) Arden Hamrick Dortha Cogar 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ratationship (Type, Print) Lennis C. Hamrick/Wife 4489 Centennial Lane Ellicott City, MD 21042 20b. Place of Disposition (Nama of cematary, crametory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o ₩ Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-30-99 Sykesville, MD Lakeview Memorial Park 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licensee Ums a 6 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immadiate Causa (Final VENTRICULAR FIBRILLATION MINUTES disaase or condition resulfing in death) Examiner Due to (or as a consequence of): Examiner VEARS ITYPERTENSION attending physician and for use as the bunal-tran Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): that the death certificate be exec DIABETES Box 68760. MELLI TUS YCARS Physician/Medical Due to (or as a consequence of): YEMRS HYPERLIPIDEMIA Part It. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown OBESITY ð 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 N No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Hospitai: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 FR/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Attending 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 2 Accidant s after death 6 Could not be datamined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) filled in by 4 Homicide ò Hospital 24 hours a 1 Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian edical (Check only one) within 2 To the 29d. Data signad (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Letters ins JULY 27, 1999 138296 15 30. Nama and addrass of person who completed ceusa of daath (Item 23a) (Type, Print) 9501 OLD ANNAPOLIS RD, ELLICOTT CITY, MB 21042 GIBBONS, M.D.

Registrar

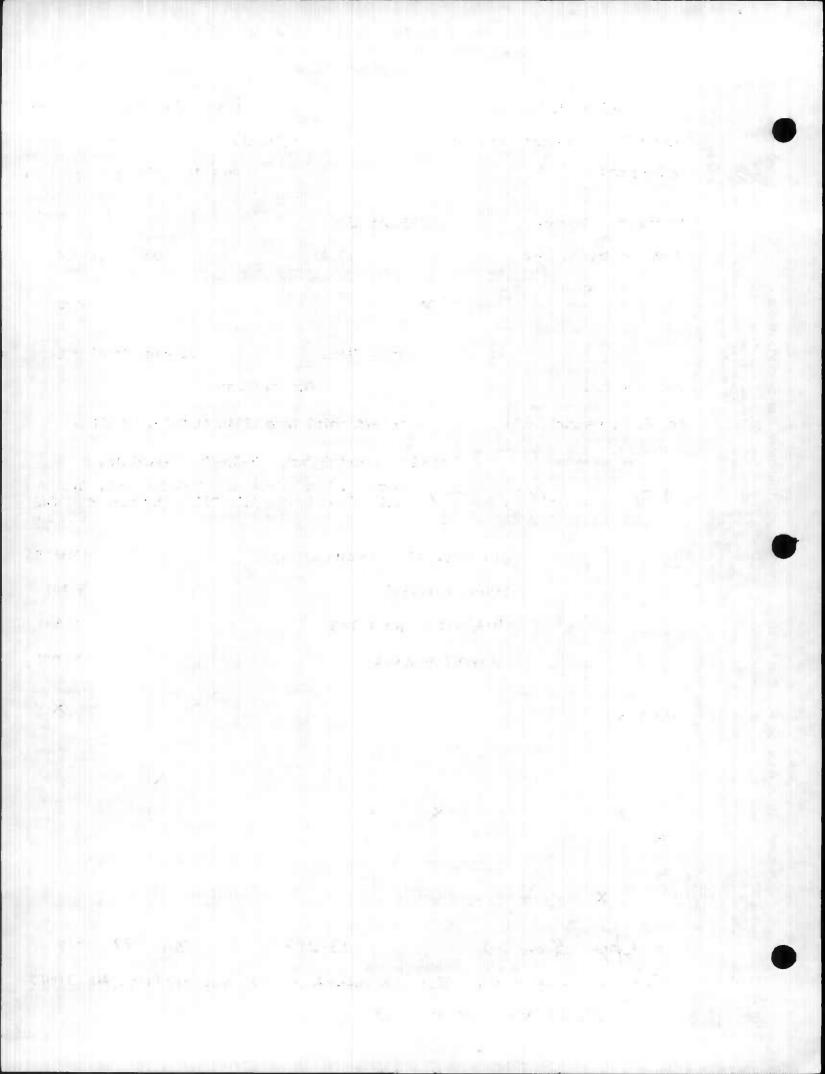
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31. Date filed (Month, Dey, Year)

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32. Registrar's Signature

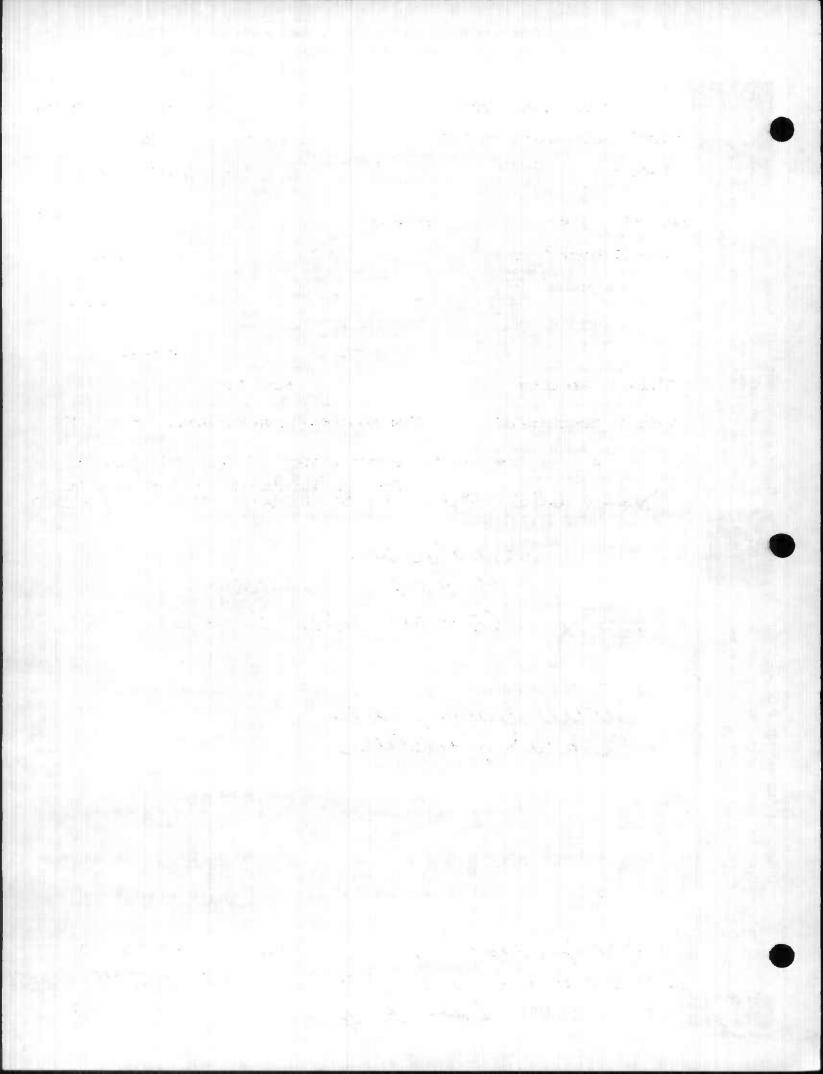


State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Data of Daath 3. Time of Death Month **Physician** Norwood E. Hendricks July 19 1999 8:30am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Howard County General Hospital Columbia Howard If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Yrs. 216-20-3967 72 Director Aug 12, 1926 Maryland Usual Residence of Dacedant the Manylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland Howard Woodstock 10g. Citizan of What Country? 10e. Street and Number 101. Zip Coda 2100-205 Ganton Green permit. Pages 1 and 2 should be filed within 72 hours effer deeth v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a and hijury or other traumatic event, the Medical Examiner marations. 21163 United States Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 11. Marital Status 1 ⊠Yas 2 □ No
If Yas, Giva
Yaar or Datas: 1945-47 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16h, Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Executive Insurance 17. Fethar's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maidan Sumama) William H. Hendricks Marie Bury 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 2100-205 Ganton Green Woodstock, Maryland 21163 Marion V. Hendricks/Wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Dothar (Specify) entembrent Loudon Park Cemetery 7-22-99 Baltimore, MD 21. Signatura of Funaral Sarvice Licansae 22. Nama and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. - whike 23a. Parti. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4112 Old Columbia Pike Ellicott City, MD 21043 Approximata Intarval Batween Onsat and Death Physician /Medical Immediate Cause (Final disease or condition resulting In death) Cardiac au Examiner Examiner hysicien end the burial-transit Sequentially list conditions, if any, laading to immadiate ceusa. Enter Underlying Causa (Disaasa or Injury that Initiated evants rasulting in daath) Last P.O. Box 68760. physicien deeth certificate be Physician/Medicai 98 esn ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown suph Sema Division of Vital Records, by 24b. Were autopsy findings availabla prior to complation of cause of daath? 24a. Was en eutopsy performed? Completed page 2 s certificate 1 ☐ Yes 2 XNo 1 ☐ Yas 2 ☐ No or Attending Physician: funeral director, 25. Was cesa refarred to medical axaminar? 26. Plece of Deeth (Check only one) Hospitat: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 TYas 2K No 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After 1X Natural 5 Panding Invastigation efter death.

Director: Aft 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 3 Suicida 28f. Location (Straaf and Number or Rural Routa Number, City or Town, Stata) 28a. Place of tnjury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 - Homicida 24 hours 29a. Cartifian 12 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the ceuse(s) and mennar as stated. Medical 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. (Check only one) within 2 To the To the 29b. Signature and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) July 19, 1999 10 30. Neme end eddress of person who complated ceusa of daath (Itam 23a) (Type, Print) FAIR MOUNT AVE BALTIMONE MD 91286 A-BEDON 515

Registrar

31. Data filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Dev Year Month July 1999 11:30 PM Jung Soon Jung 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Ellicott City 4536 Stonecrest Dr. Howard If Under 1 Year If Undar 24 Hrs. Birthplaca (Stete or Foreign Country) 7. Age (In yrs. last birthdey) 8. Data of Birth (Month, Dey, Year) 5. Sociel Security Number Deys Months 1□M 20 F Yrs 80 Sept. 18, 1918 Korea none Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4536 Stonecrest Dr. 21043 Korea 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Bleck, White, etc. 11. Merital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 □ Nevar Married 2 □ Married 1 Yes 2 No Specify: Specify: **3**OWidowed 4 □ Divorced Asian 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilega (1-4or 5+) Homemaker Own Home none 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) unknown unknown 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4536 Stonecrest Dr. Ellicott City, MD. 21043 Steven Cho / grandson 20b. Plece of Disposition (Nema of cemetery, cremetery or other place) 20c. Location - City or Town, Stata 20a Method of Disposition July 13 1 ☐ Burial 🏖 Crametion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 1999 Catonsville, MD. 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 1 Vmm 4112 Old Columbia Pike Ellicott City, MD. 21043 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heert failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in deeth) Atherosclerotic Cardiovascular Disease Years. Due to (or as e consequence of) Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Ceuse (Diseese or Injury that initiated events rasulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

certificate be exec

P.O. Box 68760,

Records,

Division of Vital

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/Medical

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10e. Stete

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r than "naturel", or items 23s or the Medical Examiner must be r

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permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any liquiry or other traumatic event, page.

altimore, Maryland 21215-0020

ician and buriel-trans physician the USB as signed t peen page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Examiner Physician/Medicai by Completed funeral director, Be To Certification:

25. Wes case referred to medical

Yas 2□ No 27. Manner of Deeth 1 Naturel 5 Pending investigation 2 Accident 3 Suicide 4 Homloide

29b. Signature and title of certifier

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

26. Place of Death (Check only one) 28c. Injury at Work?

1 Yes

Other: 4 Nursing Homa SOR asIdence 6 Other (Specify) 28d. Describe how injury occurred

24a. Wes en eutopsy

1 ☐ Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of causa of deeth?

1 Yes 2 No

12/199

21042

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. 29c. Licansa number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

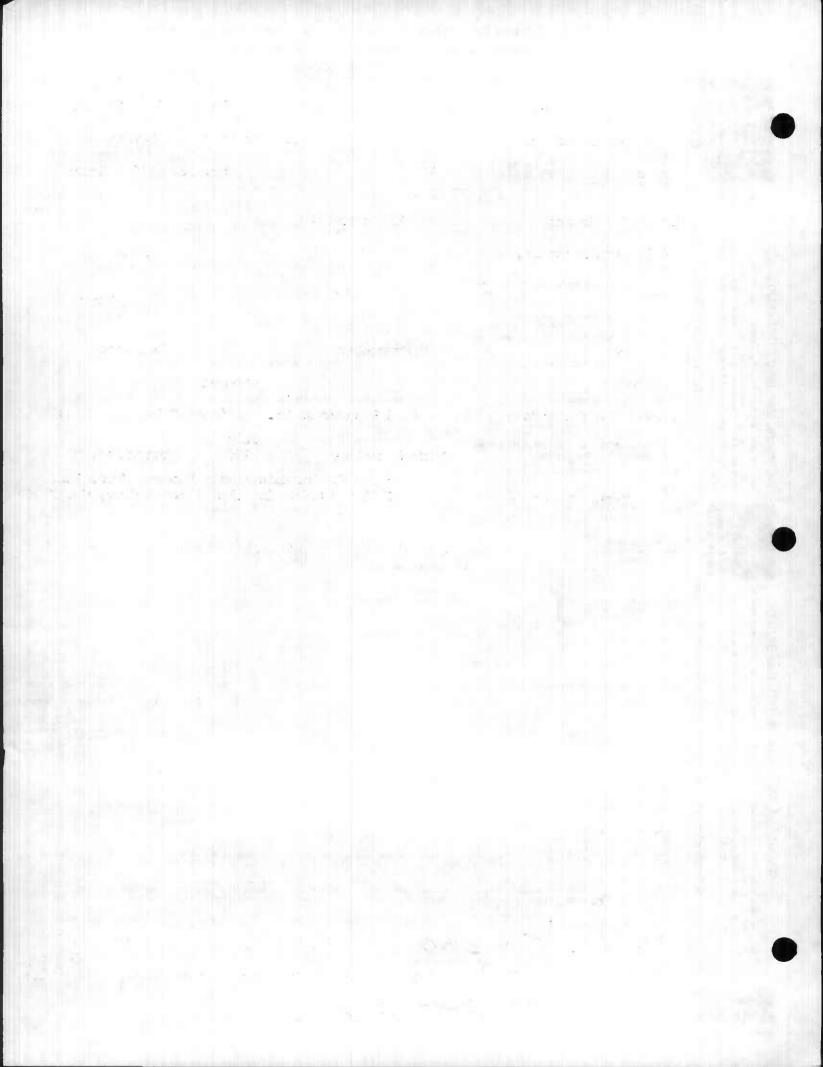
4565 Hemlock Cone Way MD (0

State Registrar

edicai

29a. Certifier (Check only one)

31. Dete fited (Month, Day, Year) 32. Registrar's Signature 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month 12:50 AM LINDSAY TOHN EDWARD 29 JUL /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner MEDICAL CENTER UNIVERSITY OF MARYLAND BALTIMORE If Under 24 Hrs. 7. Aga (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months XIXM 2DF 219-12-0278 Director MD Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Carroll Westminster 238-1 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be 952 Deer Park Road 21157 USA Funeral llams. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2∑∑No If Yes, Give 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 8 Specify: White 1 Yes 2 No Specify: þ 3 € Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Harry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Shaneybrook Co. Plumber 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 2 Albert Lindsay Bertie Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) . 3149 Cardinal Drive, Westminster, MD 21157 nt of Health a if Item 27 is or other tra Mary Hush/Daughter 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date pEBurial 2 Cremation 3 Removal from State Department of Important: If 4 ☐ Donation 5 ☐ Other (Specify) Deer Park Cemetery 7/31/99 Westminster, MD 22. Name and Address of Facility Pritts Funeral Home & Chape 21. Signature of Funeral Service Licensee 412 Washington Rd., Westminster, MD21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final SEP815 disaasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner gastric tovated The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that Initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yaa ZNNo 3 Probably 4 Unknown Records, Be Completed by ate has been signe page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 XNo edical Certification: To 1) Inpatiant 2 ER/Outpatient 3 DOA of this funeral 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No death. after death 3 Suicida 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

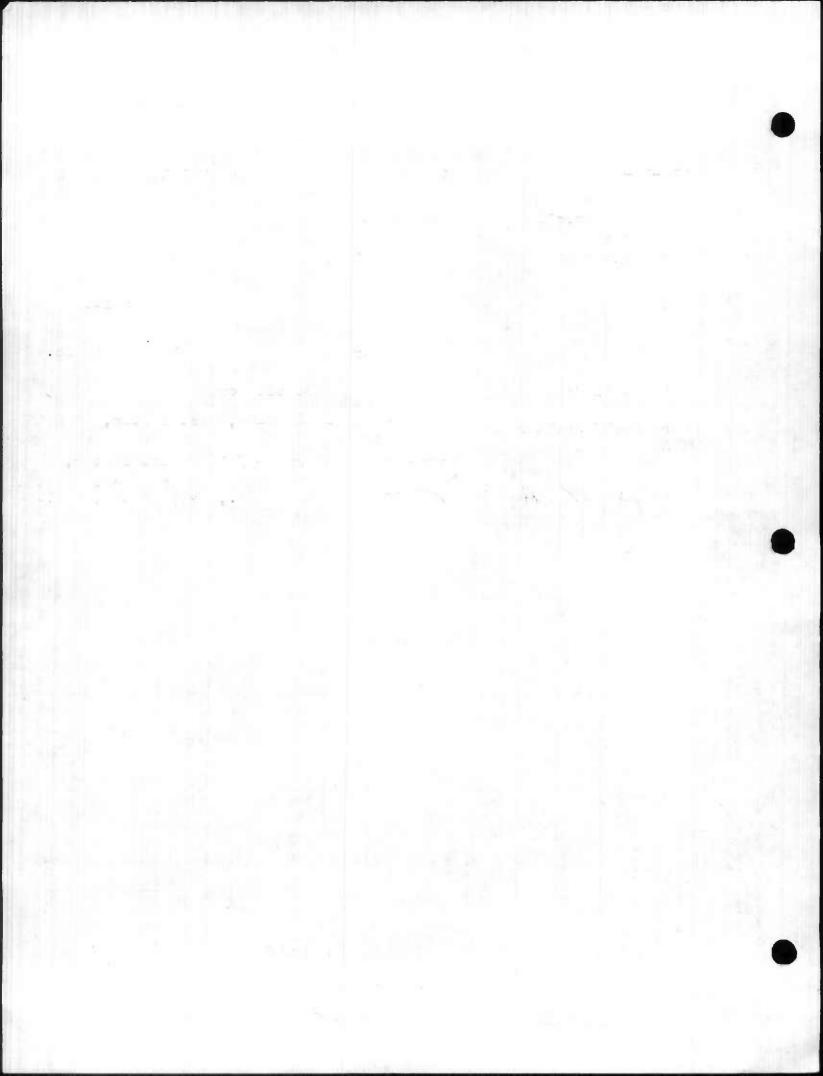
Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 2 29c. License number P1146C 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ratuna 29 REST DENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURPHY KATRINA Baltimore, MD 225. GREENE

DHMH 16 Rav 6/95

State Registrar 31. Date tiled (Month, Dey, Year)

2 9 1999

32. Registrar's Signatura



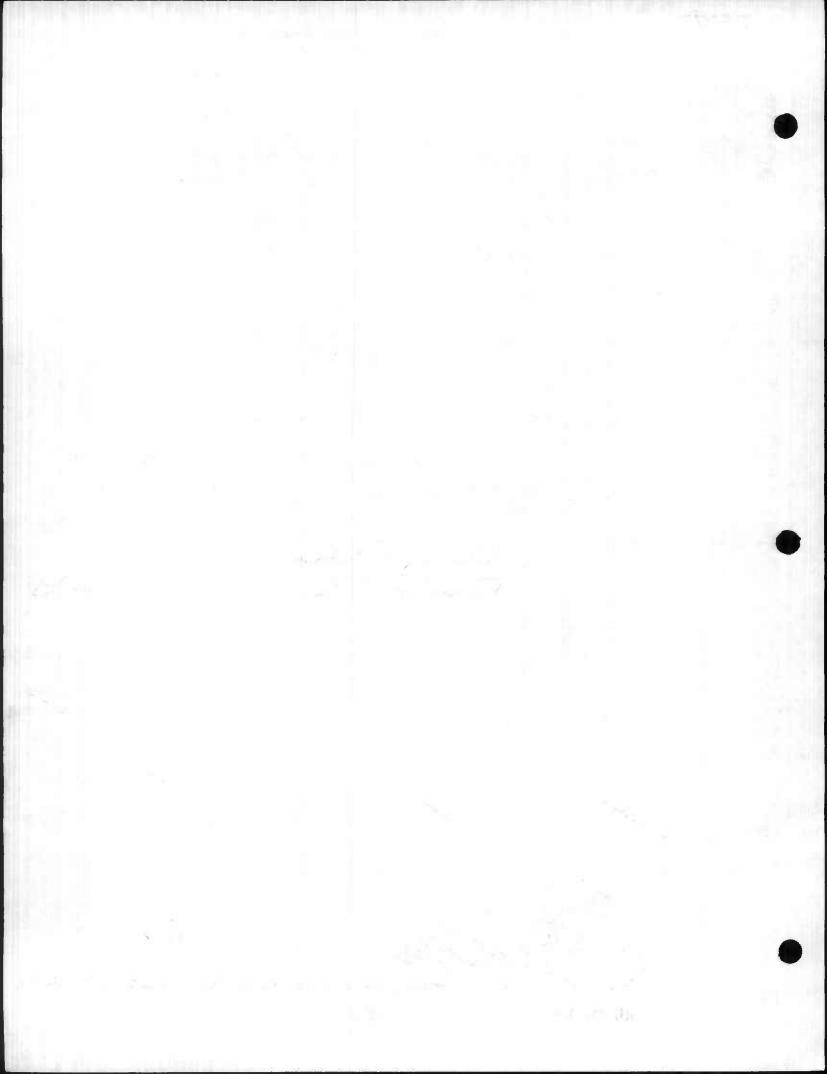
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State of Maryland / Department of Health and Mental Hygiene

_				Certificate			leg. No.	20200			
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Mary Cora Martin			2. Date of Dee Month July	Day Yea 23, 1999				
1	Examir		4e. Fecility Name (If not institution, give street and number) Carroll County General Hospit	al	4b. City, Town, or Westmin	Location of Death	4c. County of De	eath			
	Funeral Director		5. Social Sacurity Number 6. Sex 7. Age (In yrs 216–10–9224 1		Year If Under 24 Hr Pays Hours Mir		r, Year)	hirthplace (State or Foreign Country) Maryland			
	d 21215-0020 filed within 72 hours efter deeth with the Meryland Hygiene. ther than "natural", or Hems 23s or 28s-f show ont, the Medical Expedies must be recitied at	tor	Usual Rasidence of Decedent 10a. State 10b. County 10c. Co Maryland Carroll	city, Town or Location	Westminste	•		10d. Inside City Limits 1 ☐ Yes 2√ No			
		Funeral Director	10e. Street end Number 20l St. Mark's Way Apt 315	10f. Zip Co			10g. Citizen of What Country? USA				
020	ours efter deel	þ	11. Maritel Stetus 1 Never Married 2 Married 1 No Widowed 4 Divorced 12. Was Decedent Ever in User Armed Forces? 1 Yes 3 No If Yes, Giva Yeer or Dates:	U,S. 13. Wes Deceden If Yes, specify 1 ☐ Yes 2 ∑	t of Hispanic Origin? (Cuben, Mexicen, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	14. Rece - An Black, Wi Specify:	nericen Indian, nite, etc. White			
21215-0020	d within 72 ho giene. or then "netur i the Med cal	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collaga (1-4or 5+)	16a. Decedent's Usual C (Give kind of work of lifa. DO NOT use r HOMEMS	_	orking	16b. Kind of Busines				
Maryland	should be filed ind Mental Hygi i marked other umatic event, I	To Be	Eli Emory Martin		Mary	me (First, Middle, 17) Miller					
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Merylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be recitied a once.		1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State		CSOX Rd, Ne	Date 7/27 Eline Fu	r, Md 2177 20c. Location - City of Hampstea neral Home	76 or Town, State ad, MD			
	Physician /Medical Examiner	Examiner	b. Fraction	(or as a codsaquence of):	f dying, such es cerdie	ec or respiretory err	est,	Approximete interval Between Onset and Death			
Box 68760,	h certificate be executed ending physician and r use as the buriel-transit	edical	if any, laading to Immediata ceuse. Entar Underlying Cause (Diseasa or injury	(or as a consequence of): or as a consequence of):							
Р. О.	requires that the death cer een signed by the attendin hould be detached for use	by Physician/M	Part II. Other significant conditions contributing to death but not res	sulting in the underlying ceus	e given in Part I.			rite to the cause of death2 Probably 4 Unknown			
Records,	e law requir has been s ge 2 should	Completed t				24a. Was a perform	med?	o. Were eutopsy findings aveilable prior to completion of ceuse of death?			
Vital	E age	Be Co	25. Was casa referred to modical		28 Place of De	1 ☐ Ye		1 ☐ Yes 2 ☐ No			
	ysician: is certific director,	To B	examiner?	ER/Outpatient 3□ DOA	Other:		ence 8 Other (St	pecify)			
Division of	ng Ph fter th ineral		27. Mannay Death 1 Death 1 Death 5 Panding (Month, Day Year)	28b. Time of Injury M	Injury at Work?	28d. Dascribe he	ow injury occurred				
N N	ytal or Attendius after death	Certification:									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical	29a. Certifier (Check only one) 2	ation and/or Invastigation, In	ne time, date and plac my opinion, death occ cense number	urred at the time, d	ate and place, and d	ue to the ceusa(s)			
)	¥ 1 8		To light	m-	D38489		7/13/ap	o			
			30. Name and address of person was possible of death (her	Too That	Rox R	and Ha	mpteed	49 21074			

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JUL 28 1999



State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** WILBUR Mc:KINNEY **JAMES** 26, July 1999 0130 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Carroll County 4850 Ruggles Road Taneytown If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)
Apr. 22, 1926 Maryland Birthpieca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours 1 M M 2 □ F 216-22-7862 73 Yrs Director Usual Residence of Decedent deeth with the Marylend 10c. City, Town or Location 10e Stete 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be nothing at 1 ☐ Yes 2 No Directo Maryland Carroll County Taneytown 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 4850 Ruggles Road 21787 United States Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 (XYes 2 No 1945If Yes, Give 1946 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11 Maritel Stetus filed within 72 hours efter Hygiene. 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: 1946 Specify: White à 3 Widowed 4 Divorced Year or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Electrical Elementery/Secondary (0-12) Coilege (1-4or 5+) Electrician Contracting 10 other 7 is marked other trsumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Peges 1 end 2 should be in nent of Heeith and Mental int: If item 27 is marked or Frank David McKinney Paulina Stover 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Neva Kriner / Personal Rep. 4850 Ruggles Road Taneytown, Maryland 21787 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition July cemetery, cremetory or other place) 30 permit. Peges Department of Important: If it any Injury or or 1 X Burlei 2 ☐ Cremetion 3 ☐ Removel from State Westminster, MD. Meadow Branch Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1999 21. Signature of Fuperal Service Licensee 22. Name end Address of Fecility Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787 100 cur 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finei Imasive savamous cell 4 mos metastatic disease or condition resulting in death) Examiner exercinoms of the lung Due to (or es e consequence of): Examiner sician end buriel-transit requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) P.O. Box 68760. physician Physician/Medical the Due to (or es e consequence of) 88 ettending USB 5 signed by the el Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peed The law page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifice director Be 25. Was case referred to medical 28. Place of Deeth (Check only one) Hospitel: 1 | Inpetient 2 | ER/Outpetient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 20 1 Yes 2 No funerai Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) in by 4 T Homleide lilled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end menner stated. To the Hosp within 24 hou To the Funer completely fil 29a Certifie edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number D 43643

21787

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Registrar

State

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

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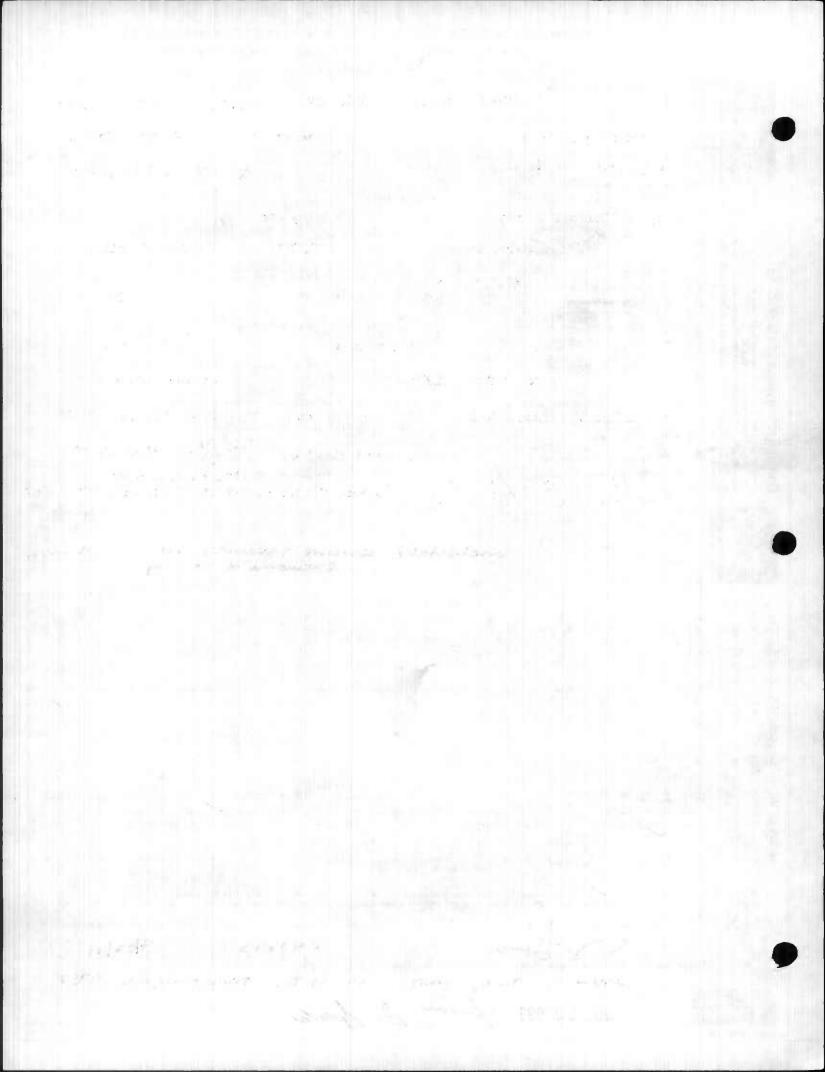
32. Registrar's Signeture

1 Kings Dr

JASON A.

JUL 2 9 1999

31. Dete filed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene ()

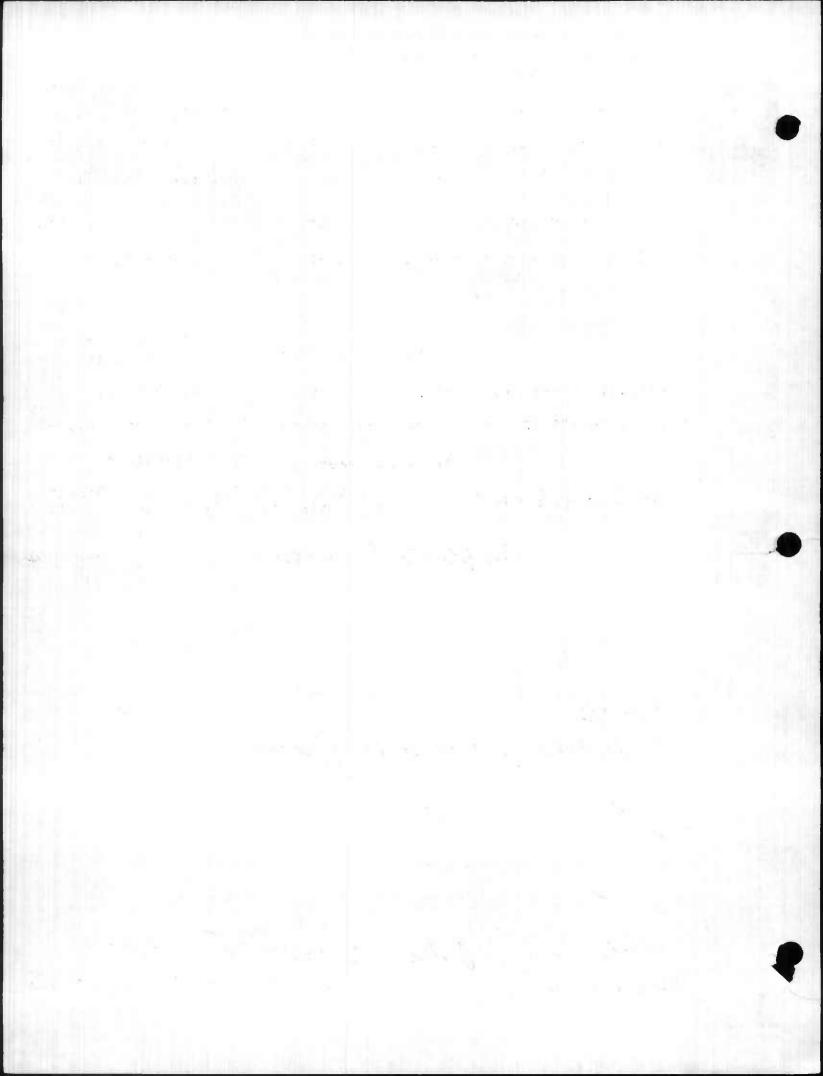
Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wilda Wolford Massi July 14, 1999 2:00 P.M. /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 616 Pensinger Blvd. Oakland Garrett If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 12-18-1941 9. Birthplace (State or Foreign Country)
WVa. 7. Age (In yrs. last birthday) **Funeral** 10M XDF Months Days Hours 236-66-4257 57 Yrs Director Usual Residence of Deceden with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Modical Examiner must be notified at XYes 2□No Director Md. Garrett Oakland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 616 Pensinger Blvd. USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examina-1 □ Never Married Married 3altimore, Maryland 21215-0020 1 Yes 2€ No Specify: Specify: White PY 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4≠2 masters Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Wolford Orpha Grace Flanagan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Tommy Massi/husband 616 pensinger Blvd. Oakland, Md. 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify) Mt. Calvary Cemetery 7-17-99 Thomas, WV. 22. Name and Address of Facility Hinkle Funeral Home P.O. Box 186 Davis, WV. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ametastatic breast cancer Examiner 5 years Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): and Box 68760 physician Physician/Medical the Due to (or as a consequence of): attending 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 Division of Vital Records, P.O. No No 3 Probably 4 Unknown signed by 1 Yes none ğ 8 24b. Were sutopsy findings available prior to 24a. Was an autopsy Completed **D880** completion of cause of death? Tan page 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Restdence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatlent 3 DOA # 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: Athar Natural 2 Accident 5 Pending Investigation 1 Yes 2 No Hospital or Attend 24 hours after death Funaral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26650 7/27/1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.; 13079 G 32. Registrar's Signature 13079 Garrett Highway; Oakland, Md 21550 Margaret Kaiser. 31. Date filed (Month, Day, Year) State AUG 1 1 1999 boaks Registrar

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State of Maryland / Department of Health and Mental Hygiene

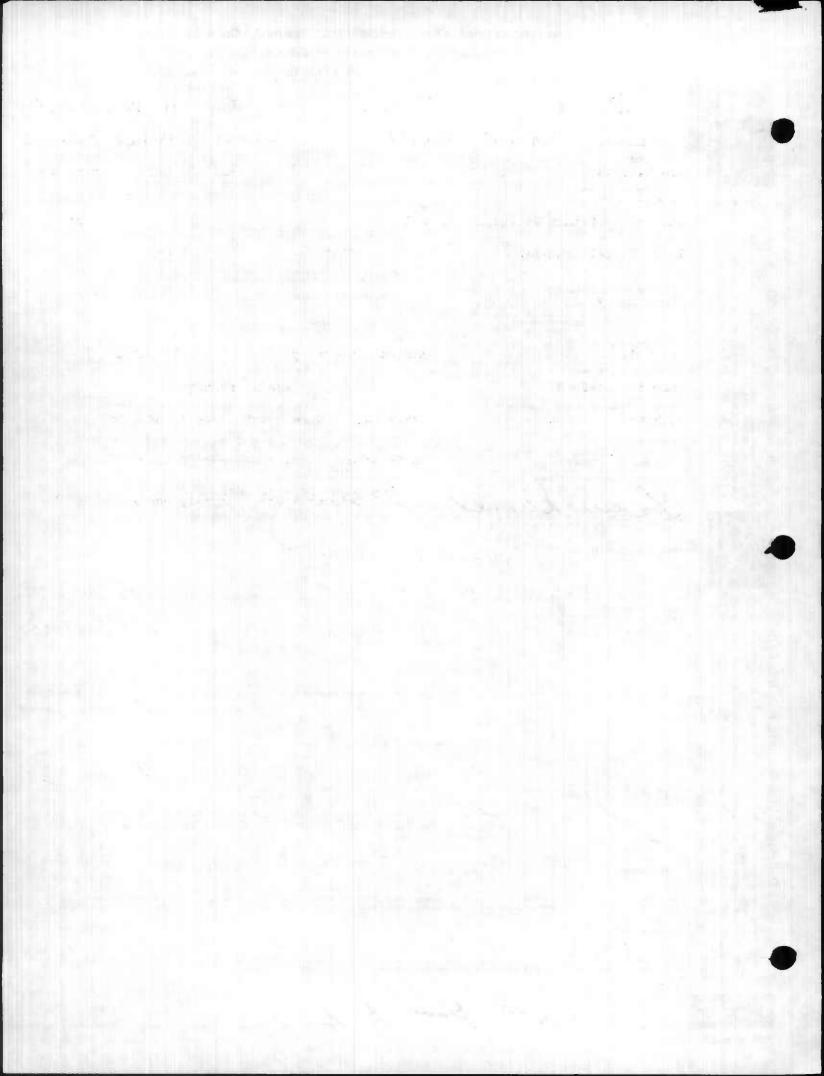
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 30 1995 th 4c. County of Deeth 4b. City, Town, or Location of Deeth Thomas Martin Marine /Medical 1700 4a. Facility Name (If not Institution, give street and number) **Examiner** 5827 Galestown-Reliance Road Seaford Dorchester, MD If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthpiace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Dev. Year) **Funeral** 1 M 2 □ F Yrs. Director 218-34-8848 82 Feb. 22, 1917 Maryland Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f show Director 1 ☐ Yes NO MD Dorchester Seaford 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5827 Galestown-Reliance Road 19973 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed The Medical 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Agriculture/ Eiementary/Secondary (0-12) College (1-4or 5+) Grain Farmer/Cattle Cattle Grower 7 is marked other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I Jessie Deborah Wheatley Benjamin Brewington Marine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 9 9 7 3 19e. Informant's Name/Relationship (Type, Print) Health a 5827 Galestown-Reliance Rd., Seaford, DE Mary E. Marine/Spouse or other t 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or pace. 8/3/99 Galestown, MD Galestown Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom-Hawkins-Eskow Funeral Home, PA 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final months disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Last Due to (or as a consequence ot) P.O. Box 68760. Physician/Medical the Due to (or as a consequence of) salgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 | Yes 2 | No Records, à 90 statu pericaideal effection 24b. Were autopsy findings available prior to page 2 should Completed 24a. Was en eutopsy performed? completion of ceuse of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Desidence Hospital: 1 ☐ Inpatient 2 ☐ ENOutpatient 3 ☐ DOA 1 Yes 2 No Certification: To 6 Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of After 1 Neturel 5 Pending Investigation To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: After completaly filled in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) Default 29d. Date signed (Month, Day, Year) 29b. Slanature and title of certifier 29c. License number 30. Name end address of person who com (Item 23a) (Type, Print) 31. Date filed (Month, Dey, Year) State AUG - 3 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Q Q 2597

			Cert	rificate of	Death		Reg. No.		0210	
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terr must be notified at liver must be notified at -uneral Director	10e. Street and Number 15035 Laurel Oaks	/hat Count	try?							
r thems 234 olimer must Funeral	11. Marital Status	12. Was Decedent Ever in	U,S. 13. W	as Decedent of I	Hispanic Origin? (Spo an, Mexicen, Puerto	ecify Yes or No	- 14. Race	- America		
Examine Dy Fur	1 Never Married 2 Married 3 Widowed 4 2 Worced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Datea:		Yes, specify Cub		Hicen, etc.)	Specify:	k, White, a	ite	
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ygiene. ser than "natura n, the Medical Completed	Elemantary/Secondary (0-12)	Coilege (1-4or 5+)			during most of works		**	- 7		
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To Be	Hubert Lunceford				Sarah J					
T	19a. Informant's Name/Relationship (1 Al Monch / Sor	**	_		tand Number or Run View Court	al Routa Numb	er, City or Town,	Stete, Zip		
other of	20a. Mathod of Disposition	20b.	Place of Dispos	ition (Name of	17	/ 1Date OO	20c. Location -	City or Tox	wn, Stata	
5 =	1 Burial 2 XXemation 3 4 Donation 5 Other (Specify	Removal from State		ematory or other ple		7/14/99 20c. Location - City or Town, Stata 6/14/99 Catonsville, Md.				
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any l	V	and	20707							
	M. Parti. Enter the disease, or companies shock, or heart failure. List only	rrest,	Approximate Interval Between							
sician	anoun, or mount failure. Class only t	one cause on each inte.						!	Onset and Death	
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nera on:	27. Manner of Death 1 Naturai 5 Pending 2 Accident Investigation	28a. Data of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo M 1	ry af irk?] Yas 2 No	28d. Dascribe	how injury occurr	ed		
led in by the funeral Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Piace of Injury - At building, etc. (Spec	home, farm, stre- ify)	et, factory, office		28f. Location (City or To	Street end Numbe wn, Stete)	er or Rura	l Routa Number,	
Completely filled in by the f		ysician: To the best of my kr linar: On the basis of examin and manner stated.								
Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	(Month, I	Dey, Year)	
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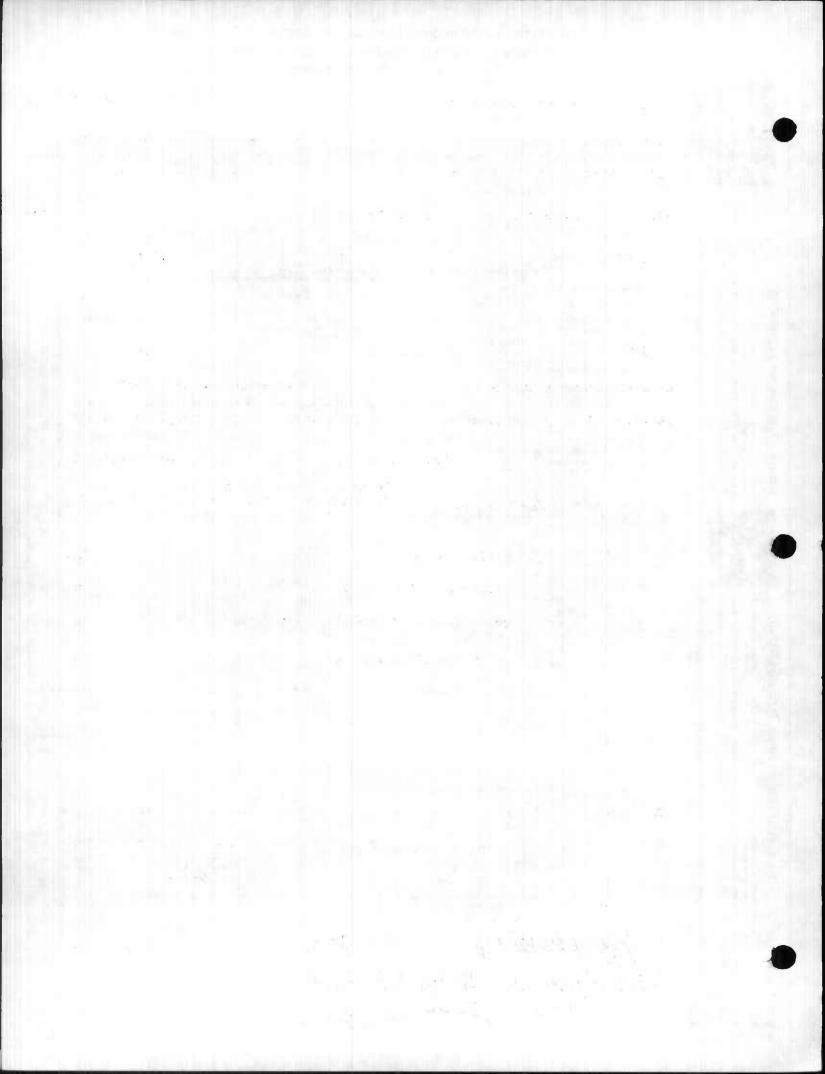


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State of Maryland / Department of Health and Mental Hygiene 999757

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State Registrar



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				•	Certificate of			Reg. No.	9 2527	2	
Phys	sician	Decedent's Name (First, Middle, Last) Emma J. McCa					2. Date of De Month	Dey	Year		
	edical	4e Facility Name (If not institution, give :	-			4b. City, Town, or	July Location of Death		.999 12:00	PM	
Exa	miner					Ellicot		Howa	Selling Transfer		
Fune	ral	2817 Greenway D 5. Social Security Number 6. Securi		In yrs. last birth	day) If Under 1 Yeer	If Under 24 Hrs	8. Date of Bir		Birthplace (State or F Country)	Foreign	
Direct		214-10-9601 Usual Residence of Decedent	M 21XF	83 Y	rs. Months Days	Hours Min	Apr. 17	, 1916	Maryland		
death with the Meryland ms 23a or 28a-f show	, io	10a. State 10b. County	1	0c. City, Town					10d. inside City 1 ☐ Yas 2		
the N	Director	Maryland Howard 10e. Street and Number		Elli	cott City			10g. Citizen of W	That Country?		
E &	급		•						States		
eath	era	2817 Greenway D	ITIVE 12. Wes Decedent Eve	er In U.S.	21042	dispanic Origin? (5	Specify Yes or No		- American Indien,		
5-0020 72 hours efter d	by Funeral	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No		to Rican, etc.)		Black, White, etc. Specify: White		
21215-0020 d within 72 hours of jiene. r than "naturel", or	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. (Decedent's Usual Occup Give kind of work done	pation during most of we	orkina	16b. Kind of Bu	siness/industry		
within ene.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retire	d)	9				
d 212 filed with Hygiene. ther the	S	12		В	eautician	10 Mathada Ma	Cosmetic her's Name (First, Middle, Maiden Surname)				
Maryland d 2 should be file the end Mental the Tamerked other traumetic avent	r other traumatic aver	17. Father's Name (First, Middle, Last)	Con				8. Mother's Name (First, Middle, Maiden Sumame) Eva Mason				
should in marke		Robert S. Jones 19a. Informant's Name/Relationship (Ty	and Number or R		er City or Town	State 7in Code)					
end 2 sho selth end n 27 is m		Jay McCarthy / so			17 Greenway						
re, N s 1 and s f Heelth tem 27 other tr		20e. Method of Disposition		20b. Place of	Disposition (Name of crematory or other pla		July 15		City or Town, State		
Baltimore, semit. Pages 1 e Depertment of Hee moortant: If Nem.		1 ☐ Burial 2 A Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Metro	Crematory		1999		ille, MD.		
Baltimo permit. Pag Depertment Important: if		21. Signature of Funeral Service License	-1 m-1		Harry H. V	ss of Facility Vitzke's Columbia	Family I	Funeral Licott C	Home, Inc. ity, MD. 21	043	
Physicia	an	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line.	e death. Do no					Approximate Interval Betwe Onset and De	en	
/Medic Examin	al	Immediate Cause (Final disease or condition resulting in death)	Deh	-y dv	ation	$\mathcal{O}_{\mathbf{m}}$		120.13	day	S	
	ne.		0	2 W to	onsequence of):				most	W	
8760, sets be executed hysician and the buniel-transit	Examiner	Sequentially list conditions,	,	010 11	onsequenca of):					V —	
38760, cete be execu physician and the buriel-trai	E E	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	WA						year	5	
0 5 08	9	resulting in death) Last	Hea	e to (or as a co	ensequence of):	iON			day	2	
, P.O. Box (that the deeth certified by the ettending deteched for use expending deteched for use expensions	Physician/M					*					
P.O. nat the d d by the deteched	hysi	Part II. Other significant conditions con	tributing to death but r	not resulting in	the underlying cause gi	ven in Part I.		Yes 2 No	Tribute to the cause of 3☐ Probably 4☐ Ur	death?	
ds, P lires that signed b	by P	NA.						100 2010	3 Probably 4 or	IKIIOWII	
peen / requi	lete						24a. Was	an autopsy rmed?	24b. Were autopsy fine available prior to completion of cau of deeth?		
I Re lev The lev page 2	Eo						10	Yes 2 No	1 ☐ Yes 2 ☐ N	lo	
f Vital Re systelen: The last contilicate he director, page	Be	25. Was case referred to medical				26. Place of De	eath (Check only	one)			
Of Vita Physician: this certific	To	examiner?	lospital: 1 🗆 Inpatient	2 ☐ ER/Out	patient 3 DOA Ott	her: 4 Nursing	Home 5₺ Resi	denca 6 Othe	er (Specify)		
Division or To the Heapital or Attending Ph within 24 hours after death. To the Funeral Director: After thi Compileley filled in by the funeral	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Ti	jury Wo	ryat ⊮k?]Yes 2 □ No	28d. Describe	5. State Residence 6 □ Other (Specify) I. Describe how Injury occurred			
Division of To the Hospital or Attending F within 24 hours after death. To the Funeral Director, Affer Completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, fan Specify)	m, street, factory, offica		28f. Location (City or To	Street and Numb wn, State)	er or Rural Route Numbe	91,	
B Hospit 24 houn Funeral	Medical (amination and				due to the cause(s) and menner as stated. It the time, date and place, and due to the cause(s)			
Vithin Fo th	Me	29b. Signature and title of cartifier	7		29c. Licens	se number		29d. Dete signed	(Month, Day, Year)		
- > - 0		* Kathleen	Mall	tung-	WD 12	201		7-11	1-99		
7		30. Name and address of person who co	mpleted cause of deal	th (Item 23a) (1		(N- 1)	0 5:6				
			apolis	KD	Ellicott (wy M	0 210	42			
	State istrar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	A. lon	1.1					

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

Physici /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or flame 23a or 28a-f ahow any Injury or other traumatic event, the Wedical Examine must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires thet the death certificate be executed within 24 hours after death.

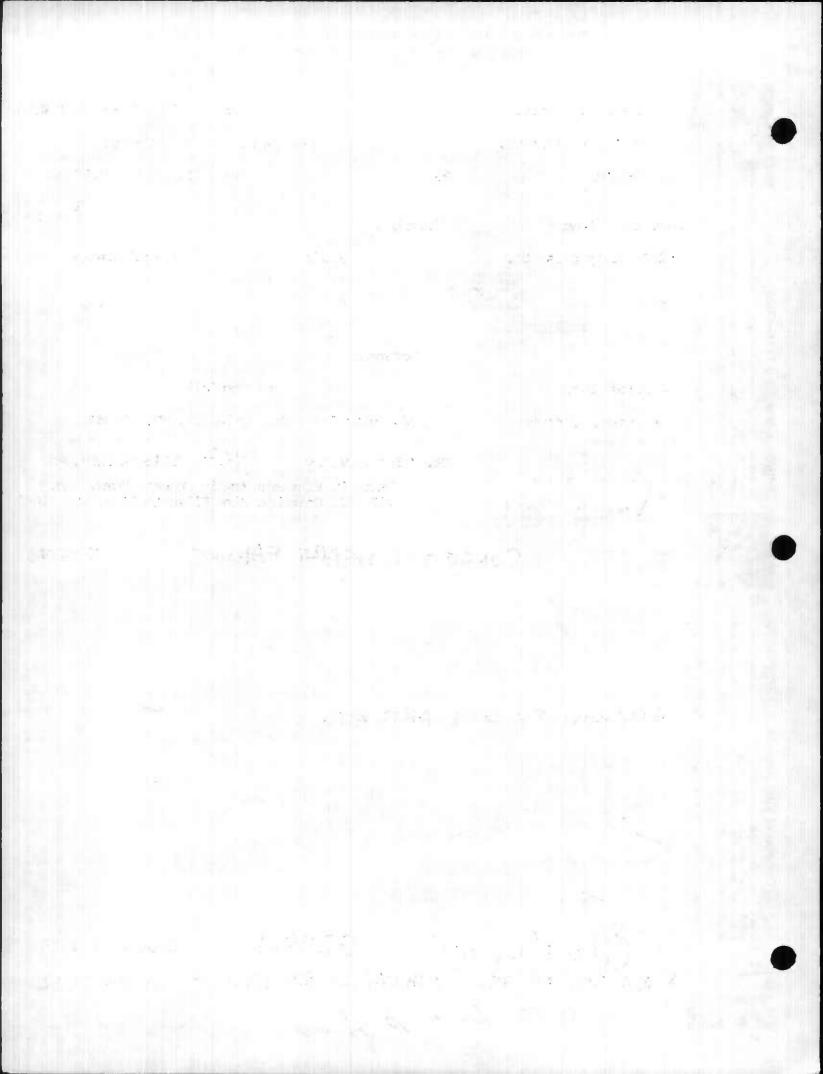
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunel-transit Division of Vital Records, P.O. Box 68760,

			Cen	ificate of i	Jeath		Reg. No.		
1. Decedent's Nema (First, Middla,	Last)					2. Data of Month	Death Day	Year	3. Tima of Death
Robert G. N	Morris					July	11	1999	6:00 A.M
4a Facility Neme (If not institution,	giva street and numb	er)		4	b. City, Town	, or Location of De	ath 4c. Cou	nty of Death	
6268 Dusty Gl	ass Ct.				Colum	nbia	н	oward	
		Age (In yrs. lest	birthday)	If Under 1 Year	If Undar 24	Hrs. 8. Data of			place (State or Foreigntry)
366-03-5505	1X M 2□ F	83	Yrs.	Months Days	Hours		11, 191	5 M	ichigan
Usual Rasidance of Decedent		0.5				nug.	11, 101	J 111	conigan
10a. State 10b. County		10c. City, T	own or Loc	ation					10d. Inside City Limits
M 77	. 5	0-1	1 . male 2 -						1 Yes 2 No
Maryland Howar	ra	Co.	Lumbia	1			10g. Cltizen	of What Cou	man /2
10e. Street and Number				10f. Zip Code					
6268 Dusty Gla				2104				ed Sta	
11. Marital Status	12. Was Decede	ent Ever in U,S. es?	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin n, Mexican, P	? (Specify Yas or Puerto Rican, etc.)		lace - Ameri Ilack, White,	
1 Nevar Married 2 Merrie 3X Widowed 4 Divorced		No No		□Yas 2√2 No	Specify:		Spe		
15. Decedent's	s Education	1	6a. Decede	nt's Usuel Occup	ation		16b. Kind o	Business/In	
(Specify only highest	grade completed)		(Give k	ind of work done of NOT use retired	during most of	f working			
Elementary/Secondary (0-12)	Coltege (1-4	or 5+)	Rever		,		Cl	erav	
17. Father's Neme (First, Middle, L			rever	.CIIU	18. Mother's	Name (First, Mide			
	•								
Charles Morris						ez Cranda			
19a. Informant's Name/Ralationsh Jan Puckett / d				Address (Street Ousty Gla		or Rural Route Nur Columb	nber, City or To	vn, Stete, Zi 2104	
20a. Method of Disposition				ition (Neme of		Date	20c. Locatio	n - City or T	own State
1 Burial 2 Cramation	3 □Removal from St	ate cem	etery, cremi	etory or other pled		July 14			
4 ☐ Donation 5 ☐ Other (Sp.		St.	Johns	Cemeter	-Y	1999	Ellic	ott C	Lty, MD.
21. Signatural Funeral Service L	Icensee		22.	Name and Addre	ss of Facility	's Family	Funera	1 Home	Tnc
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \								MD. 2104
23a. Part1. Enter the disease, or o	vmnlications that cau	sed the death						CILLY	Approximate
shock, or heert feiture. List o	nly one ceuse on eec	h line.		,					Interval Between Onset and Death
					-	٠, ,			
tmmediate Cause (Final disease or condition	CON	GEST	IVE	HEAL	70 1	Alwa	8	1	5 YEARS
resulting in death)		Due to (or es						20	
	- b							1	
Sequentially list conditions,	0	Due to (or as	s a consequ	ence of):		-			
if any, leading to immediate cause. Enter Underlying									
Cause (Diseese or Injury that initiated events	C	Due to (or as	a consequi	ance of).					
resulting In death) Last		Due to for as	- a ourisequ	a					
	d								
								1	
Part II. Other significant condition	a contributing to deat	h but not resultir	ng in the un	derlying cause giv	en in Part I.	23b. D	ld tobacco usa		to the cause of death
GENERALI	LED O'	STEND	RTI	RITIC		1	□ Yaa 2 1	6 3□ Pro	obably 4 Unknow
21		1 100		1111					
							es en eutopsy erformed?	8.	Vere autopsy findings vailable prior to
						_			ompletion of cause f death?
						4	☐ Yes 2 XN		☐Yes 2☐No
OF Manager of the Control of the Con									_ 100 ZLINU
25. Was case referred to medical exeminer?	Hospital:			oci po. Oth	OF:	f Deeth (Check on			
1 ☐ Yes 2X No	1 Li tnp		VOutpatient	3LI DOA	4 Nursi	Ing Home 50R		-	ity)
27. Manner of Death 1 ■ Matural 5 □ Pending	28a. Date of (Month,	Dey Year) 28	Bb. Time of tnjury	28c. Injur Wor	y at k?	28d. Descri	be how Injury oc	curred	
2 ☐ Accident investige	ation				Yes 2□No				
3 ☐ Sulcida 6 ☐ Could no determine	ned 288. Place of		e, farm, stre	et, factory, office		28f. Locatio	n (Street and Ni Town, Stete)	mber or Ru	rel Route Number,
→ □ Homicide	building	, etc. (Specify)				Cny or	i own, olelej		
29a. Certifier 1 Certifying	Phyalcian: To the be	est of my knowle	dae death	occurred at the tir	ne, dete end :	place, and due to t	he cause(s) and	menner as	ststed.
	xaminar: On the basi	s of examinetion							
~~	and manne	orateu.		29c. Licens	e number		29d. Date si	ned (Month	Day Year)
29b. Signature and the phoentiper	100	AA A		29C. LICENS	9911	9	Zou. Date St	MILIONI) DOING	1900
MINU	wh	MAN		VL	110)	70	41	41177
30 Name and address of person w	no completed cause	ot death (Itam 23	3g) (Type, F	rint	0				
30 Name and address of person w	MD 950	1 OLO	BUNK	HOUS	140	Fellicis	TT CITY	Mo	21042
19 . 010		, 500	- 4-1				12 0 117		-1-1

Registrar

31. Date filed (Month, Day, Year)

JUL 13 1999



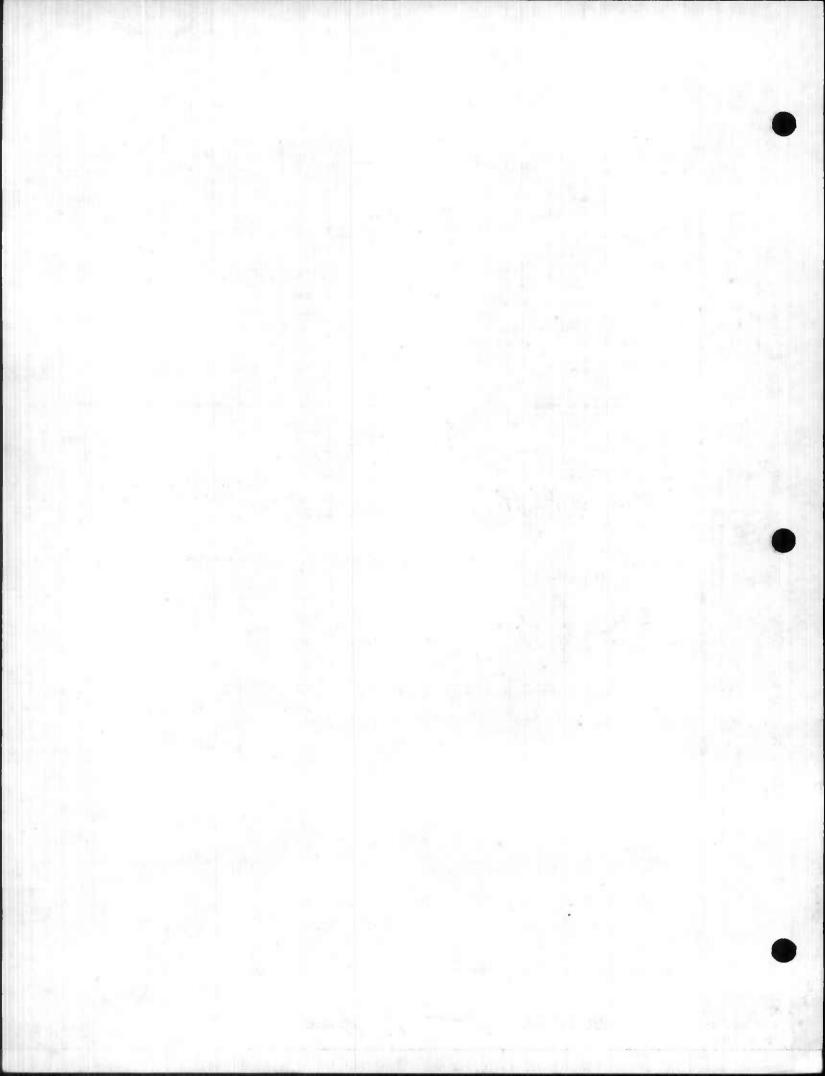
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ician	Decedent's Name									2. Date of Do	eath Day	Vana	3. Tima of Deat			
dical	Micha	ael Jo	seph	Ottey						JULY	18,19	99	2:20P.M			
niner	4a Facility Nama (#	not institution, g	ive street and n	umber)			4			ocation of Deal	th 4c. County	y of Death				
	6260 WASH							ELKR1			HOWAR					
al or	5. Social Security Nu 215-70-24	109	Sax 1₩ M 2□ F	7. Aga (In yrs. 43	· last birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Bi (Month, Di Feb 15	av. Year)	9. Birthi Cour Mary	place (State or Form ntry) yland			
	Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	ocation						11	10d. Inside City Lin			
ŏ	VA	Hen	rico	R	ichmond	E							1 □ Yas 2 □			
Director	10e. Street and Num	nber				10f. Zip	Code				10g. Citizen of	What Coul	ntry?			
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Funeral	11. Marital Status		12. Was De Armed F	cedent Evar in U	J,S. 13.	J.S. 13. Was Decedent of Hispanic Origin? (Specific Mexican, Puerto Ric					0- 14. Rac		can Indian,			
by Fu			1X Yas	2 □ No Sive		1□Yes 2		Specify:			Cassifu					
			Yaar or	Dates:				-al		WILL						
Completed	(Special	15. Decedent's I ify only highest g	rade completed		(Give	dent's Usua kind of wor DO NOT us	rk done a se retired	ation during most d)	of work	ing	16b. Kind of Business/Industry					
Mo	Elementary/Secon	ndary (0-12)	College 4	(1-4or 5+)	5.00	s Man					Telemarketing Firm					
17 H 19 C		First, Middle, Las	st)	٩		18. Mother's Name (First, Middle, Maiden Surname)										
			Cecelia <u>Kidke</u> Kipke													
	19a. tnformant's Ner										ber, City or Town					
	Cecelia		nother	leat					our				l, MD 210			
		Cramation 3			Place of Dispo cematery, crer				1	July22	20c. Location					
		5 Other (Spec	-) 170	oudon P				-	1999	Baltimo	ne,				
	24: Signature of Fun	neral Syrvice List	W /	/	B	2. Name and	d Addra:	ss of Facility Sons	у . Р.	A. Sev	erna Pai	rk Fu	noral Ho			
	GA.	08%	No	Som	4	95 Go	v. R	litchi	e Hv	w. Se	verna Pa	ark,	MD 2114			
	23a. Paper. Enter the	disease, of contract failure. List one	nplications and	caused the dea	Barranco & Sons, P.A. Severna Park Funeral H 495 Gov. Ritchie Hwy., Severna Park, MD 211 234 Part Enter the disease of complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Interval Between Park Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral H Approximate Interval Between Park Funeral Funer											
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1	Immediate Cause (F disease or op dition resulting is death)	Final		ROSCLEROT	TIC CARDI	IOVASCU				or respiratory i	arrest,		Interval Between			
1	Immediate Cause (F disease or condition resulting is death)	Final		ROSCLEROT		IOVASCU				or respiratory i	arrost,		Interval Between			
amine	disease or condition resulting is death)	Final		ROSCLEROT Due to (TIC CARDI	IOVASCU				or respiratory t	arrest,		Interval Between			
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State of Maryland / Department of Health and Mental Hygiene

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		1. Decedent's Neme (First, Middle, La					2. Date of Dear	th	3. Tima of Death	
Į,	Physician /Medical	Mollie Per	ry Pierson				July	26 ⁵ 1999 Y	10:45 pm	
	Examiner	4a Facility Name (If not institution, gh				4b. City, Town, or L		4c. County of	Deeth	
		Carroll County			עו If Under 1 Yea	Westmins		Carro		
	Funeral Director		Sex 7. Age (In y 74 74	rs. last birthda Yrs.	Months Day:		8. Date of Birth (Month, Day) March 2	, Year) 5 1925	Birthplace (State or Foreign Country) Tennessee	
	hend was	10a. State 10b. County	10c.	City, Town or I	Location				10d. Inside City Limits	
	Meny to to	MD Carro	11	Sykesv	ille				1 X Yes 2 □ No	
	ter deeth with the Meryler thems 23s or 28s-1 show lost main be notified at Tuneral Director	10e. Street and Number 7460 Jennifer W	ay	g.	10f. Zip Code 217		1	0g. Citizen of Whi USA	at Country?	
21215-0020	by F	11. Marital Status 1 Never Merried 2 X Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 Tho If Yes, Give Year or Dates:	1 U,S. 13	Wes Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bleck,	American Indien, White, etc. white	
5-0	"natural",	15. Decedent's E (Specify only highest gro		/Gin	edent's Usual Occi	e during most of work	ina	16b. Kind of Busin	ness/Industry	
121	ed within 72 ho yglene. In the material ft, the Medical	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life.	DO NOT use retir	ed)		Spring Grove Hospita		
		17. Father's Name (First, Middle, Last)	DIE	etician	18. Mother's Nam	e (First Middle I		stove nospital	
lan	A S O O	James Perry				Nancy F		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Maryland	Health and 2 sho Health and am 27 le me ther treum	19a. Informant's Name/Relationship (Type, Print)	19b. Me	iting Address (Stree	et and Number or Rui	ral Route Number	, City or Town, St	ate, Zip Code)	
M		Willie Pierson	(husband)	7460) Jennife	r Way, Syl	esville	MD 2178	4	
Baitimore	Pages 1 and ment of He mut: If Nem ury or other	20a. Method of Disposition 1 Burlal 2 Cremetion 3 4 Donation 5 Other (Special	Removel from State S	7/30/99	20c. Location - Ci West Fr	iendship, MD				
Bait	permit. Peg Department Important: h eny injury o	21. Signature of Funeral Service Lice	hant.		P.O. Bo	ress of Facility Ha			me & Chapel	
		23a. Part1. Enter the disease, or comshock, or heart tailure. List only	picetions that caused the d	eeth. Do not e	nter the mode of dy	ying, such es cardiac	or respiretory err	est,	Approximate Intervel Between	
	Physician	Harrist State of Control of Contr							Onset and Death	
T	/Medical Examiner	Immediate Cause (Finet disease or condition resulting in death)	a. Gron	ary	ante	my di	ا مصاد	L	1)10yea	
П		1 cooking in dozday	Due to	o (or as e cons	equence of):)				
	executed in and iel-transit Examiner		b.	2 (01 00 0 0000	200000000000000000000000000000000000000				ì	
ć		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due (c	o (or es a cons	equence or):					
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Box	signed by the ettending be detected for use detected for use by Physician/M		0							
P.0.	the de ched ched	Part It. Other significant conditions of	contributing to death but not	resulting in the	underlying cause g	given in Part t.			ibuta to the cause of death?	
	igned by be dete	dia).	ctes m	ellit	us		1 Y	aa 20 No 3	Probably 4 Unknown	
Vital Records,	requirement house						24a. Wes e		24b. Were eutopsy findings available prior to completion of cause of death?	
Re	The le		*				1 D Y	es 22 No	1 ☐ Yes 2 Ø No	
ta	sicion: The law irector, page 2 a lirector, page 2 a O Be Compli	25. Wes case referred to medical				26. Place of Dea				
	> = 0	axaminer?	Hospitel: 1 ☐ Inpatient 2	ER/Outpati	ent 3 DOA	Other: 4 Nursing Ho	ome 5 Reside	ence 6 Other	(Specity)	
ion of	Attending Ph or death. ector: Atter th by the funeral iffication:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Dete of Injury (Month, Day Year	28b. Time Injury	W	ury et ork? ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred		
Division	tal or Attending P ns effer death. at Director: Attent led in by the funera Certification:	3 Suicide 6 Could not be determined		t home, larm, s	street, lectory, office	9	28l. Location (Si City or Town		or Rurel Route Number,	
	To the Hospital or Attending Ph. Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 12 Certifying Pt (Check only one)	ysician: To the best of my lininer: On the basis of exam and manner steted.	knowledge, des inetion and/or	ath occurred at the investigation, in my	time, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and mannate and place, and	er as stated. d due to the cause(s)	
	within To the comp	29b. Signature and title or certifier			29c. Licer	nse number	2	9d. Date signed (Month, Day, Year)	
		1 V	(1.1)		D	47704		7/2	7/99	
		30. Name and address of person who	completed cause of death (I	tem 23a) (Type	e, Print) 400	o old c	NO	2120	8	
	State	31. Date filed (Month, Day, Year)	32. Registrer's Sig	gneture	G. Soi		1			
	Registrar	JUI 28	1999 Dene	wa	D. Sol	21/2/				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:55 Am **Physician** PSDIR FRAN CSS A. 1999 TULY 21 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COUNTY GENERAL HOSPITAL Corumsia Horman morro If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foraign Country) **Funeral** Months Days 1 M 2 XF Hours 217-34-8801 May 3, Director 81 1918 Maryland Usuel Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yas 2 XNo Director 238-7 Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 10799 #328 Hickory Ridge Road United States Berns 23s 21044 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within if Health and Mental Hygiene. Nem 27 is marked other than " Elementery/Secondary (0-12) College (1-4or 5+) Nurses Assistant Hospital 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) William E. Hatfield Margaret A. Wright 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Mitchell/Daughter 983 Old Woodbine Road Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, Stete Pages 7 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 7-23-99 Baltimore, MD Baltimore National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Nama end Address of Facility Harry H. Witzke's Family Funeral Home, Inc. llino a 0 ue. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Daeth **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical SEPTIC 6 INVIES SMOZIC Examiner Due to (or as a consequence of): Physician/Medical Examiner SEPSIS 24 HOURS sician and buriei-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): MEUTROPEMIA DAYS 68760 The law requires that the death certificate be that initieted events resulting in death) Last Due to (or as a consequence of): the Commo TUFRAPY Box 087 P.O. Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 21 No 3 Probably 4 Unknown multiple my groma Records, À Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings RENAME FAILURS, AWTS available prior to completion of cause of death? 1 Yes 2 No 1 Yes 20 No of Vital 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred i or Attending P After Division 5 Pending investigation 1 Waturel Injury after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signatura and title of ceditors 29c. License number 29d. Date signed (Month, Day, Year) D 36974 JULY 21 1995

State Registrar

30. Nema and address of person who completed cause of d

JUL 2 2 1999

DAVID O. MANSISM MO

31. Dete tiled (Month, Day, Year)

DHMH 16 Rev 6/95

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eath (Item 23a) (Type, Print)

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32. Registrade Signature

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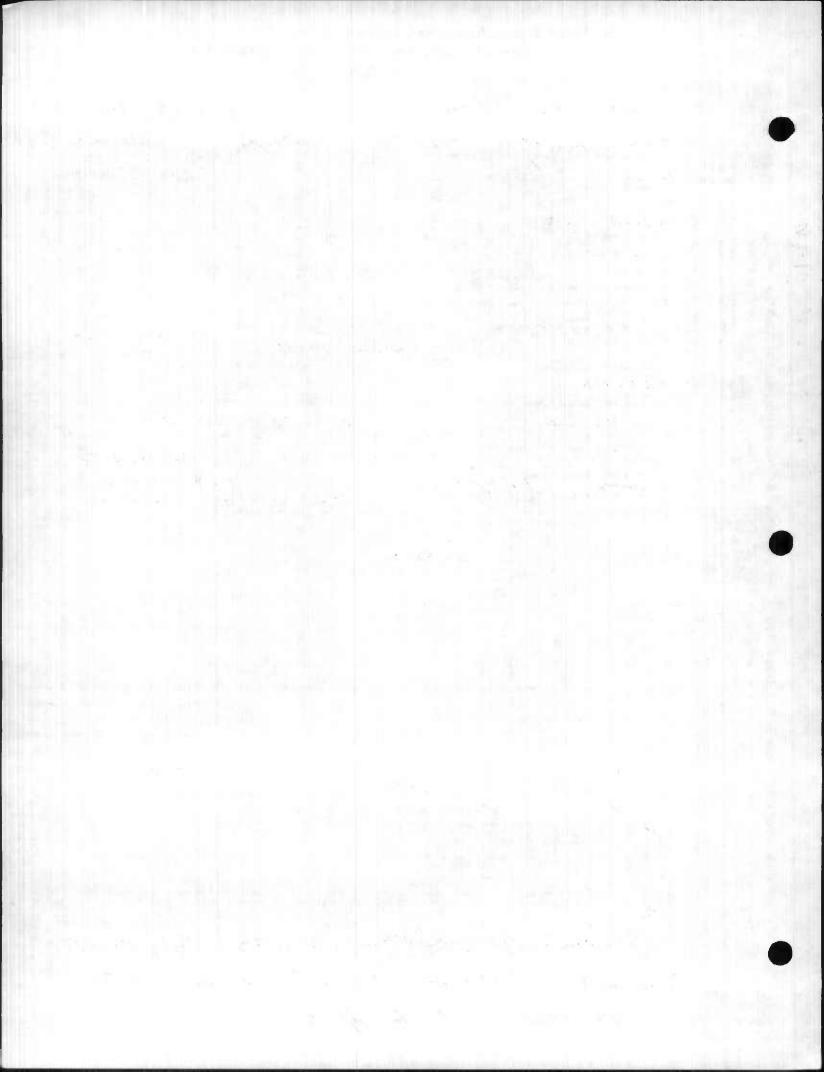
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Britan . and and an arms and THE RESERVE CAMPANIA TAMAN and the all and Secure Policies of the State of

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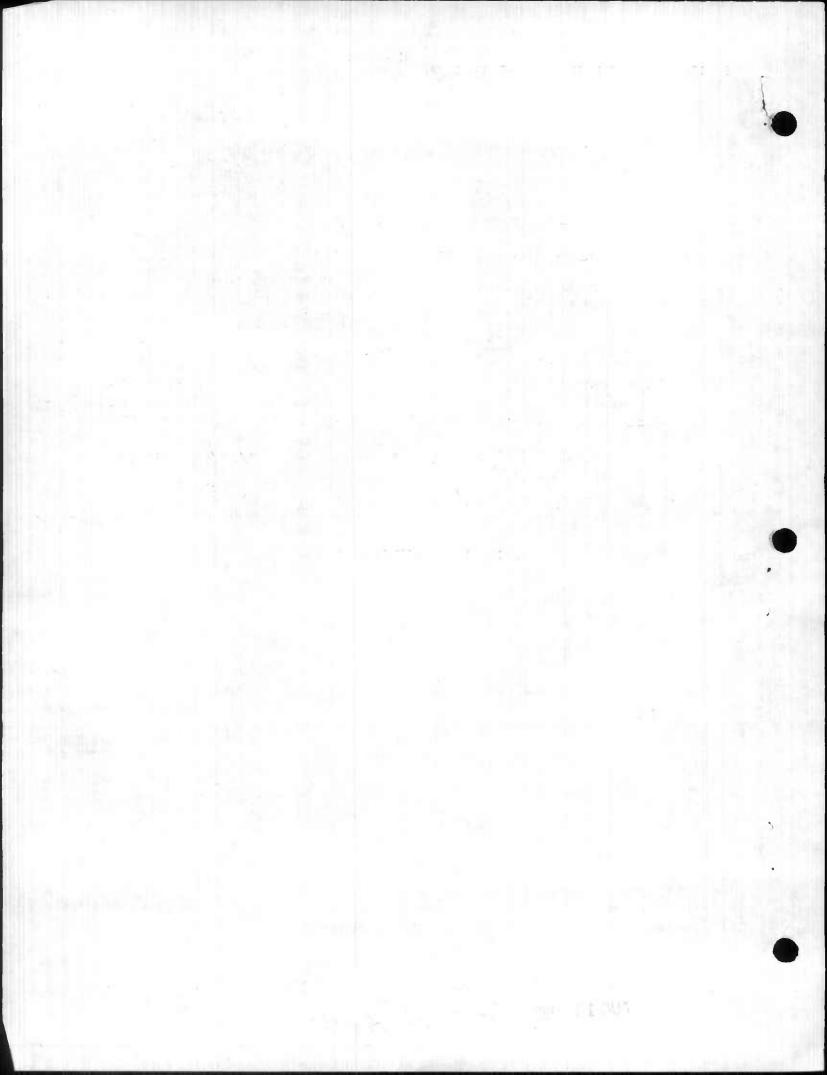
			State of Maryland	d / Department of Health and M Certificate of Death	rental Hygiene	25277
		Dharataitan	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
		Physician /Medical			July 24 199	9 10:357
		Examiner Funeral Director	4a Fecility Name (If not institution, give street and number)	ast birthday) Yrs. 4b. City, Town, or Lo Ballongot Ballongot H Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Bi	
	h	2 >	Usual Residence of Decedent	, Town or Location	•	10d. Inside City Limits
		show of	10000	Sparks		1 ☐ Yes 2 ☐ No
Q8		The N	Maryland Baltimore 10e. Street and Number	10f. Zip Code	10g. Citizen of What C	
314		rier death with the Marrier terms 23a or 28a-1s	16833 Yeoho Road	21152	USA	
3		Geath Coath	11. Marital Status 12. Was Decedent Ever in U,S Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	
30.	Maryland 21215-0020	by	3℃ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 🏖 No Specify:	Rican, etc.) Black, Wh. Specify:	White
3	5-0	led within 72 ho lygiene. Nor than "naturi it, my Medical Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ing 16b. Kind of Business	
1.1	121	hen hen	Elementary/Secondary (0-12) College (1-4or 5+)	College Professor	Johns Hop	
0	d 2	Hygiene. Wher there out, the	17. Father's Name (First, Middle, Last)		Universit e (First, Middle, Maiden Surname)	- <u>Y</u>
a	lan	should be fill and Mental H marked out urmatic even	Eli C. Renn	Ada Ea	sterday	
en	ary	and M and Is mar!	19e. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rura	4	Zip Code)
		Heelth a tam 27 la tam 27 la other tra	Eli C. Renn, son	16833 Yeoho Rd, Sparks	s, Md 21152	
2	altimore,	of He	20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State	ace of Disposition (Name of emetery, crematory or other place)	Date 20c. Location - City o	r Town, State
0)	ti m	. Pages Iment of I tant: If its jury or or	4 □ Donation 5 □ Other (Specify) Ca		7/25 Hampstead,	, MD
	Bal	permit. Pages 1 and Department of Heelth Important: if item 27 any injury or other to once.	21. Signature of Fyneral Service Licensee & Elle	22. Name and Address of Facility 934 South Main St,	Eline Funeral Home . Hampstead. Md 21	
		Physician /Medical Examiner	resulting in death)	Do not enter the mode of dying, such as cardiac of the second of the sec	or respiretory arrest,	Approximate Interval Between Onset and Death
		in the second		as a consequence ory.		
	,0	incate be assecuted physician and is the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or	as a consequence of):	and the same	
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	٥.	es that igned b be deta bv Pt			1 1 108 2 No 3	Probably 42 Olikilowii
	cords	been s should			24e. Was an autopsy performed?	. Were autopsy findings available prior to completion of cause of death?
	Re	certificate has rector, page 2			1 Yes 2 No	1 ☐ Yes 2 ☐ No
	ta			26. Place of Deat	th (Check only one)	
) t	r this certific ral director,	1 Yes 2 No Hospital: 1 Inpatient 2 I		ome 5 Residence 6 Other (Sp	ecify)
	U S	ther the unera	27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pending 28e. Date of Injury (Month, Dey Yeer)	Injury Work?	28d. Describe how Injury occurred	
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	_	ne nospita in 24 hours he Funeral pletely filled	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my know and manner stated.	viedge, death occurred et the time, dete end plece, ion end/or investigation, in my opinion, death occurr		
4		To the comp	29b. Signature and title of certifier Johnton Tuno Mored Ra	29c. License number	29d. Date signed (Mod 2 July 24	nth, Day, Year)
	_		30. Name and address of person who completed cause of death (Item Son what A-Puns A, MD.	23a) (Type, Print) 22 South Greene St., Bill	triore, us. 21	201
		State Registrar	31. Date tiled (Month, Day, Year) 32. Registrar's Signat	lure		



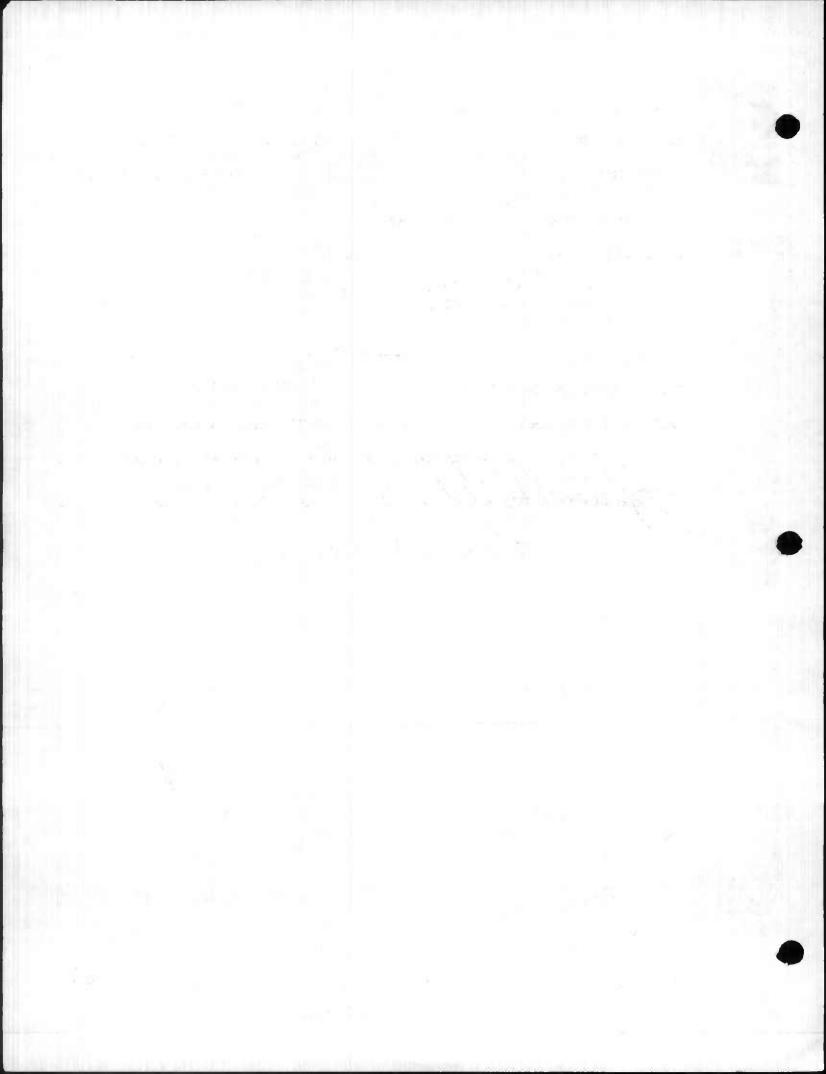
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an	1. Decedent's Nama (First, Middle	e, Last)		EO G774 <i>Ce</i>			2	2. Data of Dea Month	Reg. No.	Year	3. Tima of Death	-
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ner	Washington A			+-1							•	
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ò										'	Od. Inside City Limits Yes 2 □ No	
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	7723 Easter		Decedent Ever 1 Forces?		. Was Decedent of if Yes, specify Cu	912 Hispanic Orig	gin? (Speci	fy Yes or No-		e - Amaric	an Indian,	
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	3 Widowed 4 Divorced	If Yes, Year o	or Dates:		1 ☐ Yes 20XIN	o Specify:			Specify	r. DJ	Lack	
	15. Decedent (Specify only highes	's Education	ed)	16a. Deci	edent's Usual Occi	upation e during most	of working	,	16b. Kind of Bu	usiness/Inc	duatry	
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	19a. Informant's Neme/Relationsh			19b. Mail	ling Address (Stree	et and Numbe	r or Rural I	Route Numbe	r, City or Town,	Code)20912	_	
	Matthew N.		son (H	Husb.)	7723 E							
	20e. Mathod of Disposition		2	0b. Place of Disp	position (Name of ematory or other pl			Data	20c. Location -			
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Registrar DHMH 16 Ray 6/95



		Decedent's Name (First, Middla, Last)		C	ertificate of	Death	2. Data of Dea	Reg. No.		3. Tima of Deeth
Physici	an	PHILLIP THEODORE R	OCCRACH ID				Month	Dey	Year	
/Medic		4e. Fecility Neme (If not institution, give st		•		4b. City, Town, or	JULY Location of Death		of Deeth	12:20AM
Examin	ici	715 RICHWIL DRIVE				SALISBUR	RY	WICOMI		
Funeral		Sociel Security Number 6. Sex		s. last birthda	y) If Under 1 Yea Months Deys			h V. Year)	9. Birthp	lece (Stete or Foreign
Director		218-07-8450	M 2□F 79	Yrs.	Months Boy	110013	JULY 27	, 1920	NEBR	ÄŚKA
M 11		Usuel Residence of Decedent 10a. State 10b. County	10c. (City, Town or	Location				1	Od. Inside City Limits
fled a	to	MARYLAND WICOMICO		SALISB	URY					1 XYes 2 No
natural", or items 23s or 25s-f show olical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of Whet Co		itry?
23a c		715 RICHWIL DRIVE			21804			USA		
E 2	Funerai	11. Maritel Stetus	2. Was Decedent Evar in Armed Forcas?	U,S. 13	B. Was Decedent of	Hispenic Origin? (S ban, Mexican, Puar	Specify Yes or No-	14. Rac	an Indien,	
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	PHILLIP THEODORE RO	OSSBACH, SR	MARCELI	A WEHAGE						
	19e. Informant's Name/Reletionship (Type		19b. Me	iling Address (Stree	et end Number or R	u <i>ral Rou</i> te Num <i>be</i>	r, City or Town,	Stete, Zip	Code)	
	MARY CLARA ROSSBACE 20s. Method of Disposition			RICHWIL position (Neme of	DRIVE, SA	LISBURY,			Charles Charles	
	1 □ Burial 2 Semination 3 □ Rec	moval from State	cemetery, c	ametory or other pl		- 400 40-	20c. Location -			
	4 □ Donation 5 □ Other (Specify) 21. Signature of Fungful Service Licenses	-/ / 1	AMBRID	GE CREMAT 22. Name end Add		1/20/99	CAMBRID	GE, I	MARYLAND	
	* House	1 3/		ELLER FUN	ERAL HOME					
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sician	L	ert1. Fittar tha diseese, or complication on the shoot or heart feilure. List on cone	ceuse on aech line.		^	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	o or roopirotory on	,		Intervel Between Onsat and Death
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r use	Physician/M	d.:		·					<u> </u>	·
he an	sici	Pert II. Other eignificant conditions contri	buting to death but not re	esulting in the	underlying cause g	iven in Pert I.	23b. Did t	obacco use coi	ntribute to	the cause of death?
gned by me a be deteched f							101	ON SE SON	3 Prol	bably 4 Unknown
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should should	Completed						24e. Wes a	med?	CO	eileble prior to mpletion of causa
page 2	E E							1		death?
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byt	1111	3 Suicide 6 Could not be determined	28f. Location (S City or Tow	itreat end Numb n, Stete)	er or Rura	l Route Number,				
5 E	building, etc. (Specify)									
lo the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) 2 Madical Examina	e, and due to the durred et the time, d	ceuse(s) end me dete end pleca, o	nner es si end due to	teted. tha cause(s)				
aldmo	Mec	29b. Signature and title of certifier	end menner steted.		29c. Licar	nsa number		29d. Date signed	d (Month.	Dev. Year)
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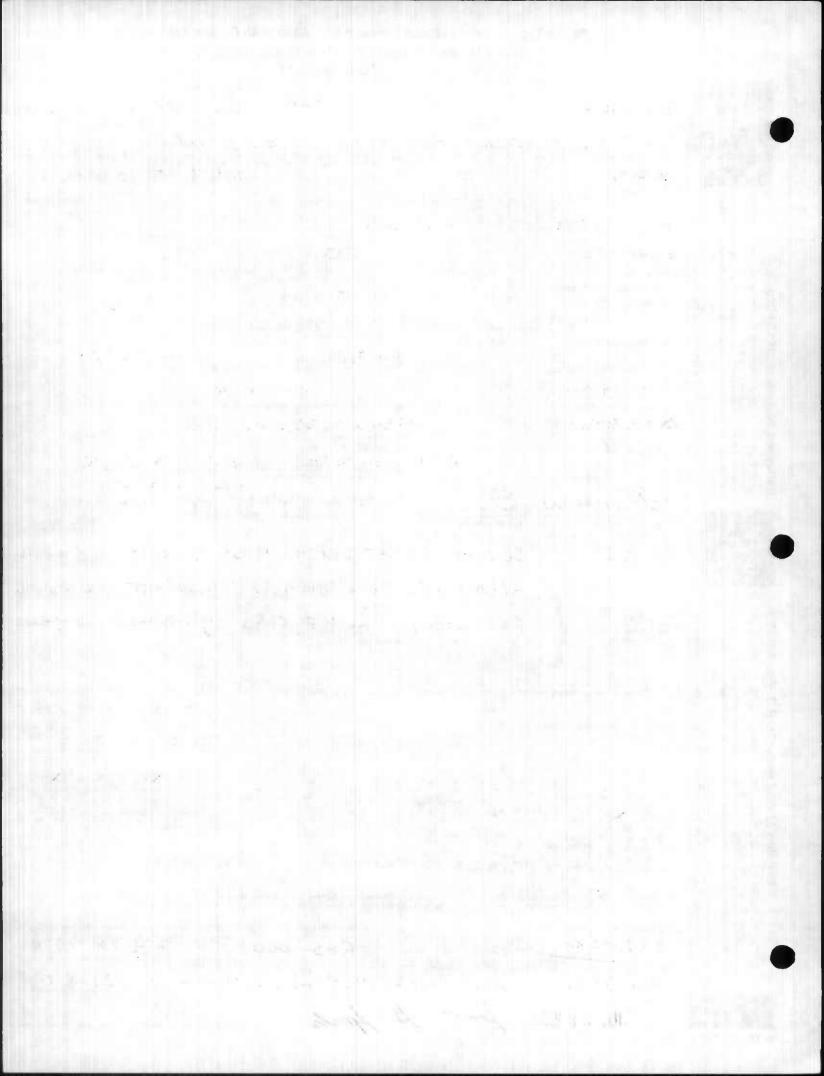


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State of Maryland / Department of Health and Mental Hygiene 0

Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Neme (First, Middla, Last) **Physician** STAUB ATRICK 28 July 1999 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOSPITAL 1. Salfimore Md
If Under 24 Hrs. 8. Date of Birth HOSPKINS The Johns 7. Aga (In yrs. lest birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours 18 M 2□ F Yrs. 164-34-2111 50 April 21, 1949 Director New Oxford, PA Usual Residence of Decedent with the Manyland permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mentel Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show with Injury or other traumatic event, the Medical Examiner must be nortified at page. 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo PA Gettysburg, PA Adams 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 966 Bon Ox Rd. 17325 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Rece - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade complated) Elementery/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Auto Parts/Sales 17. Fether's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maldan Surneme) J. Randolph Staub Evelyn Unknown Billman 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Janet M. Staub, Wife 966 Bon Ox Rd., Gettysburg, Pa 17325 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State Carroll Cremations, Inc. 4 ☐ Donetion 5 ☐ Other (Specify) July29.1999 Hampstead, MD 22. Name end Address of Fecility 21. Signatura of Funaral Sarvice Licenses Eline Funeral Home Sleven 934 South Main St, Hampstead, Md 21074 23a. Pert1. Enter the disease, or complications that caused the daeth. Do not antar the mode of dylng, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsat and Deeth **Physician** /Medical severe Graft Versus Host Disease Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner Loseneic Bone Marrow Transplant physician end the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest -Hodakin's Division of Vital Records, P.O. Box 68760, Refractory Non Physician/Medical Dua to (or es a consequence of): for use as signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ The law requires 24b. Were eutopsy findings aveileble prior to completion of cause of death? been si 24e. Wes an autopsy Completed certificate hes t 1 Yes 2 No Physician: 25. Wes casa referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Dey Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Mennar of Death 28c. Injury et Work? Certification: After 5 Pending investigation or Attanding 1 Neturel To the Hospital or Attandin within 24 hours efter death. To the Funeral Director: Af completely filled in by the fu 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Csrtifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) end menner es stated.

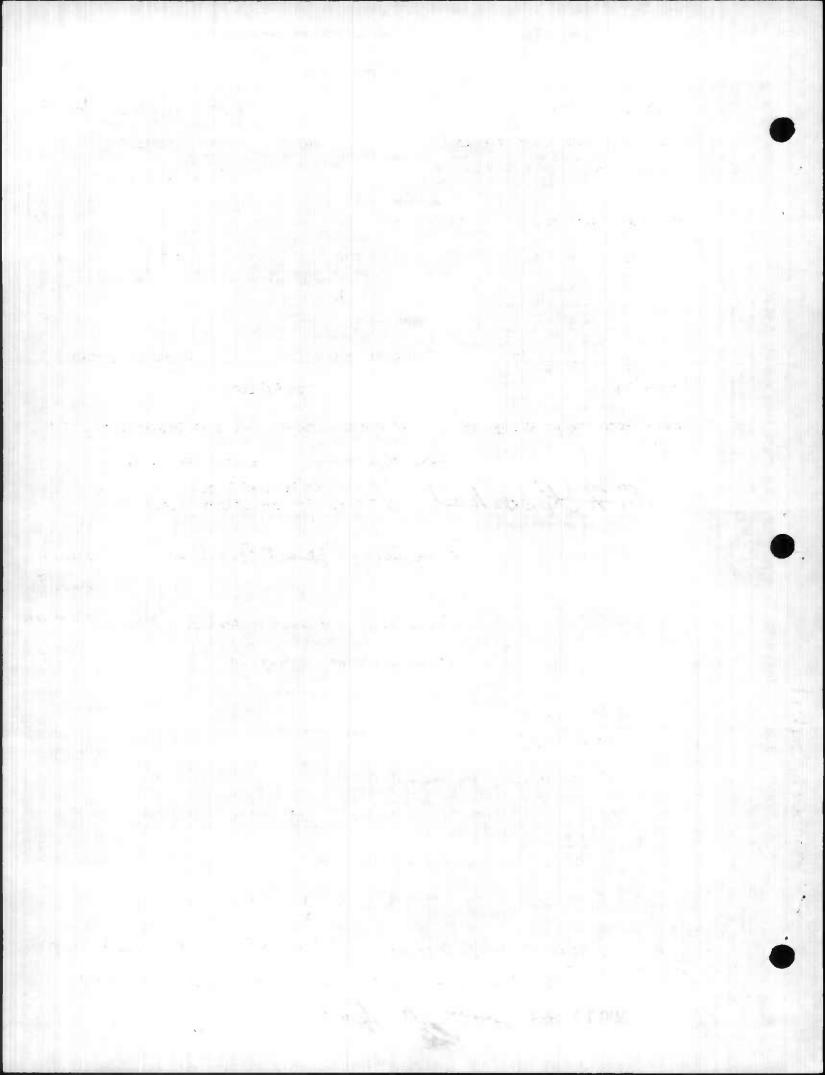
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifiar 29c. License number eng RES-000 , MUD. 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 600 North Wolfe Street Johns Hopkins Hospital, Baltimore, MD 21287 YANG MID. 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar 2 9 1999



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State of Maryland / Department of Health and Mental Hygiene

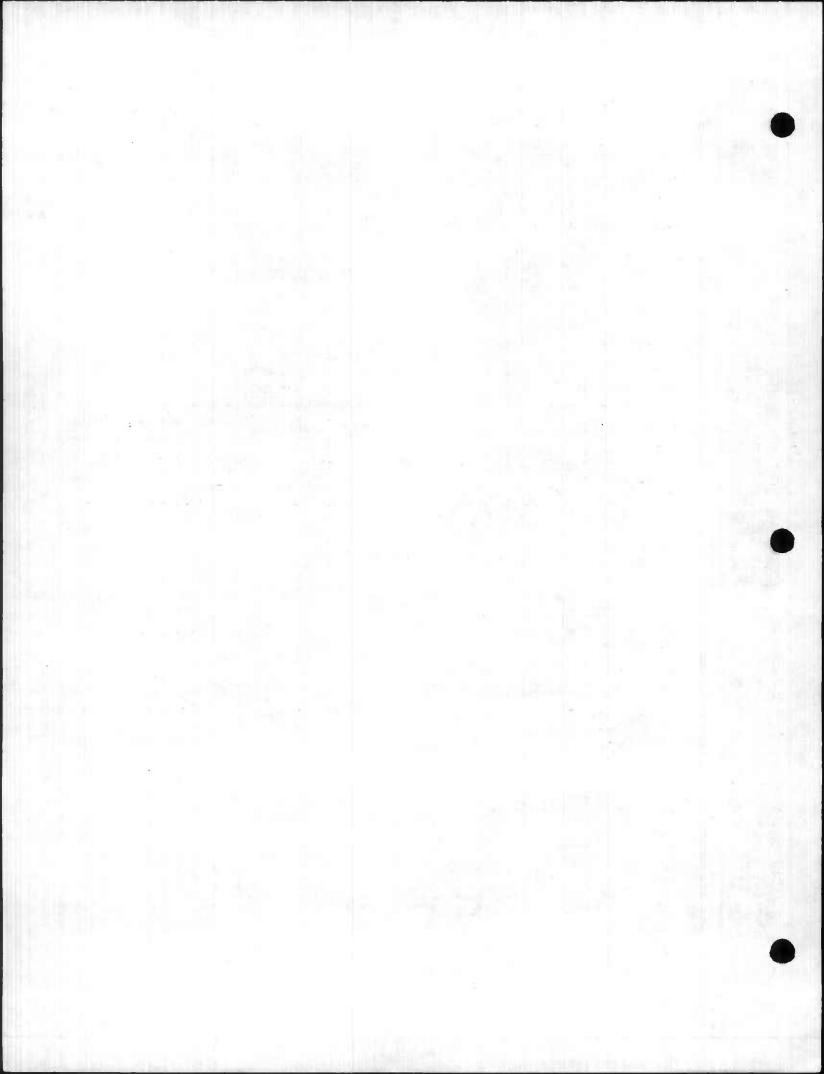
	1. Decedent's Name (First, Middle, Last	")		ertificate d		2. Date of Death		3. Time of Death
Physician	Sybil E. Steve	nson				Aua.	Dey Year	12:10pm
/Medical Examiner	4a Facility Name (If not Institution, give				4b. City, Town, or	Location of Death	4c. County of Dea	ath
Examine	Mariner Health Ca	re of BelA	ir		BelAir		Harford	
Funeral Director	5. Social Security Number 6. Se 216-09-4063	7. Age (i	In yrs. last birthda Yrs.	y) If Under 1 Ye Months Da	ar If Under 24 Hrs	(Month, Day,		rthplace (State or Foreign country)
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Marylar of show fied at	N.C. M.							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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Other death with the Ma ritems 23s or 28s-fs siner must be notifies Funeral Directo	7017 Mount Vista F	Road		21087			U.S.A.	0011171
death command	11. Maritel Status	12. Was Decedent Eve Armed Forces?	er in U,S. 13		of Hispanic Origin? (Suban, Mexican, Pue		14. Raca - Am	
Dy E	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		1 ☐ Yes 2XX		no Rican, etc.)	Specify:	nite
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121 han han mpl	Eiementary/Secondary (0-12)	College (1-4or 5+)			ne during most of wo			
C Proposition 2	6 yrs. 17. Father's Name (First, Middle, Last)	n/a	Chemi	cal Tech		me (First, Middle, N	lenn L. Ma	ertin
land d be fill ked oth c sven o Be	Harry Shipley				Ida Gil		allow our alloy	
T T T	19a, Informant's Name/Relationship (7)	ype, Print)	19b. Ma	iling Address (Str	reet and Number or Fi		City or Town, State,	Zip Code)
E T 84 M	Naomi Ruth Knauer	(Daughter)	7017	Mount. V	ista Rd.	Kingsvil	le.Marylan	nd 21087
0 -5 5 5	20a. Method of Disposition		20h Place of Dist	position (Neme or remetory or other	f		20c. Location - City o	
Pages hant of ary or o	1 XBuriat 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from Stete	Loudon P	ark Ceme	tery	B/7/99 B	alto.MD.	
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7	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused the	e death. Do not e	enter the mode of	dying, such as cardia	c or respiratory arre	ist,	Approximete Interval Between
Physician	The second secon				1 0	12 -		Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	onges	time	Hart	failu	re	years
and the same		Du	e to (or as a cons	equence of):				10- 72-
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	resulting in death) Last		Deru	Pitus	ula	14		years
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P.O. Box at the death cert d by the attendin whiched for use	Part II. Other algnificant conditions con		not resulting In the	underlying cause	given In Part I.	23b. Dld to	bacco uss contribu	te to the causs of death?
	Och CV	+				1 U Ye	8 2 No 3□	Probably 4 Unknown
d by	old 1	10				24a. Was ai	autoney 24b	. Were autopsy findings
lete show sel	orn P	l L				perform		available prior to completion of cause of death?
I Rec	Varent	En De	222 0	Là		1□ Ye	s 20 No	or death?
Vital Reduction: The law certificate has meter, page 2	25. Was case referred to medical	ar re	- or or or or		26 Plane of D	eath (Check only on		1 1 1 8 2 1 NO
	examiner?	Hospital:	2 ER/Outpati	ient 3 DOA			nca 6 □Other (Sp	ecity)
g Phy g Phy neral c	27. Manner of Death	28a. Date of Injury (Month, Dey Y		of 28c.	njury at Work?		w injury occurred	
Division of union of the desire destination of the fundament of the fundam	1 Netural 5 Pending 2 Accident investigation	(Month, Day F	out, injury		1 Yes 2 No			
IVIS racto racto racto racto racto	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, : Specify)	street, factory, off	ice	28f. Location (St. City or Town	reet end Number or I , Stete)	Rurel Route Number,
O SECT O								
he Hospi n 24 hou he Funer plansity fil	29a. Certifier 1 Cartifying Phy (Check only one) 2 Medical Exami	sician: To the best of n	amination and/or	ath occurred at th Investigation, In n	e time, date and plac ny opinion, death occ	e, and due to the ca curred at the time, de	iuse(s) and manner a ete and piaca, and di	as stated. ue to the cause(s)
2 444	29b. Signeture end title of cartifier	and manner stated	3.		ense number		9d. Dete signed (Moi	
· 6 \$ 6 .	1 Pul S	Fr Bla	M :1		D1638			
	30. Name and eddress of person who co	ompleted cause of deat	h (Item 23a) (Tim		- 0	1	Jus	Tille
1 11 1			(10011 23d) (1yp	LADEN	non PA	1100-1	MD 210	1/7
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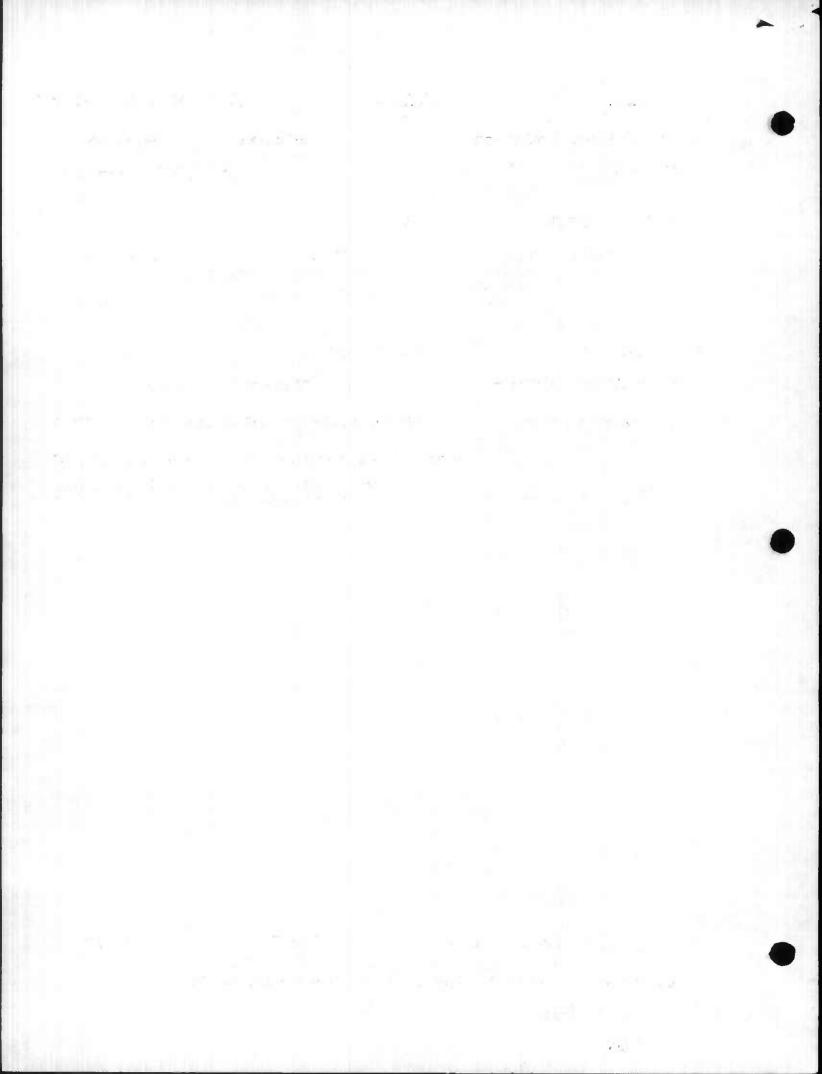
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/Medica	Marchall Irven St	eele					July	31,	1999	0732
Examine							Location of Deat	_	nty of Death	
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Funeral Director		X M 2 F	74	Yrs. Mont		Hours Min		ay, Year)		place (Stata or Foreign htry) yland
	Usuel Rasidence of Decedent		/ 4				Aug 2,	1924	rial	yland
thow the	10a. Stete 10b. County		10c. City, T	own or Location					1	0d. Inside City Limits
or 28a-f show be notified at	Maryland Caroline		Gree	nsboro						1 ☐ Yes 2 No
2 0 2 De De	10e. Street and Number				Zip Code			10g. Citizen o	f What Cour	ntry?
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3 22 1	13200 Greensboro 11. Marital Status 1 Never Merried 2 Married	12. Was Deceden Armed Forces 1 Yes 2 T	?	If Yes,	specify Cubi	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	etc.) Black, White, etc.		
DO DO	3 Widowed 4 □ Divorced	Year or Dates							Wh	ite
15-0 n 72 ho natur edical	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		1	6a. Decedent's U (Give kind of tife. DO NO	work done	during most of w	orking	16b. Kind of	Business/In	dustry
vething within the Man	Elementary/Secondary (0-12)	College (1-4or	5+)	Equipme				State	High	way
DI Hyg	17. Father's Name (First, Middle, Last)			Equipme	оре		ama (First, Middle	1		way
Vian Montal Manual Mised	Rufus Henry Steel	e				Eva M	ay Swens	on		
a de la la la la la la la la la la la la la	19a. Informant's Name/Relationship (Type, Print)	1	19b. Mailing Add	ress (Street	and Number or I	Rural Route Numb	er, City or Tow	vn, State, Zip	Code)
	Virginia Hutson					orner Rd	Hartle	y Delaw	vare 1	9953
Pages 1	20a. Method of Disposition 1 XBurial 2 Cremetion 3 C	Removal from State	come	e of Disposition (etery, crematory	Name of or other place	ce)	Date	20c. Location	n - City or To	own, State
tim Page tant: Page	4 □ Donation 5 □ Other (Specify	y)		sboro C			Aug 3,1	999 Gre	ensbo	ro,Maryland
Baltimore, permit. Papes 1 ar Department of Hee Important. If fem 3 any injury or other ance.	21. Signature of Juneral Service Licen	-	0	Fleeg.	le & F		in Funer sboro, M			639
	23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that oduse	ed the death. D						1 21	Approximate Interval Between
Physician	arout, or many turiors, sist only				_					Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	. 1	SPAIN	Stem	ST	ROKE				DAYS.
	rasulting In death)		Dua to (or as	a consequence	of):					
executed in and tal-transit		b							1	
n and isl-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or as	a consequence	of):					
760 se be se bur	Cause (Disease or Injury that initiated events	C	Due to (or as	a consequence	of):					
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IS, P.O. BOX 6 es that the death certification igned by the attending to be detached for use as	Pert II. Other significant conditions of				,			tobacco use	contribute t	the cause of death?
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of Vital Records, Physician: The law requires th this certificate has been signed ral director, page 2 should be d								an autopsy	245 W	ere autopsy findings
The law requires rate has been sign, page 2 should be	STARUS	EPILE	OTICV:	5				ormed?	av cc	ailable prior to impletion of cause
Vital Rec										death? □Yas 2□No
far in the street or, page or,	25. Was case referred to medical					36 Place of D	eath (Check only	Yas 2 No	11	J Yas 2∐ No
Of Vita Physician: this certific ral director.		Hospital: 1 Inpat	ient 2□ER/	/Outpatient 3□	DOA Oth	ior-	Homa 5 Ras		Other (Specia	V)
Physer this neral di		28a. Data of Inj	jury 28	b. Time of Injury	28c. Injur Wor		28d. Describe			,,
Attending In death.	1 Natural 5 Pending Invastigation		ay routy	М		Yes 2 □ No				
Division of the national part of the transfer	3 Suicide 6 Could not be determined	286. Place of Ir	njury - At home	, ferm, street, fac	tory, office			(Street and Nui wn, Stata)	mber or Run	al Route Number,
Division of the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Madding Cartification.										
n 24 hour ne Funer pletely file	29a. Certifier 12 Certifying Phy (Check only 2 Medical Exam	ysician: To the best niner: On the basis	of axamination	dge, death occur and/or Investigat	red at the tir tion, in my o	ne, data and place pinion, death occ	ce, and due to the curred at the time,	date and place	manner as a e, and due t	tated. the cause(s)
To the Hospital within 24 hours a To the Funeral completely filled		end manner s	itated.		29c. Licens	e number	T	29d. Date sig	ned (Month	Day, Year)
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	Scott D. Friedman			1 Court	Ea	ston, Ma	aryland	21601		
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Registrar	AUG - 3	ושאם בכבו	eperation	10.	MOUNT	and the same				

Marshall Steele



State of Maryland / Department of Health and Mental Hygiene Amended #4c, 07/28/99, PCT, Howard Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Sellers Frances July 6:45 A.M. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ridgeway Manor Nursing Home Baltimore Baltimore NONE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foraign Country) 6. Data of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗆 F Days Yrs. Director 217-09-6106 85 Feb 15, 1914 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 25s-f show the Medical Example: prust be notified at 10d. Inside City Limits 1 Yes 2 XNo Director Maryland Howard Ellicott City 10a. Street and Number 10f. Zlp Code 10g. Citizen of What Country? death with 8930 Old Frederick Road 21043 Funeral United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 10 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American indian, Bleck, White, etc. d 2 should be filed within 72 hours after the end Mental Hygiene.
It is marked other than "natural", or itel traumatic event, the Medical Exercises. 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes 200 No Specify: by Specify. 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) Elementary/Secondery (0-12) College (1-4or 5+) unknown Textile Worker Textile Baltimore, Maryland 17. Fethar's Name (First, Middla, Last) 16. Mother's Name (First, Middle, Maldan Surname) Be Peges 1 and 2 should be Inent of Heelth end Mental Int. If Item 27 is marked of Arthur William Shifflett Florence M. unknown 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth e Important: If item 27 is any injury or other trai Mary France/Daughter 8930 Old Frederick Road Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cramation 3 ☐ Removel from State Good Shepherd Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 7-30-99 Ellicott City, MD 22. Name and Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funerei Sarvice Licensee 0 Co 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or heart feilura. List only ona causa on each line. Approximeta Intervai Between Onsat and Death Physician Immedieta Cause (Final disaasa or condition resulting in deeth) /Medicai Devent'a Examiner 40000 Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted evants resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Jackineonera. Hyporepoil Division of Vital Records, 5 8 Completed by 24b. Ware autopsy findings available prior to Peripheral Vascoron Disase 24e. Wes an autopsy performed? completion of cause of death? 1 Tas 2 -NO 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death.

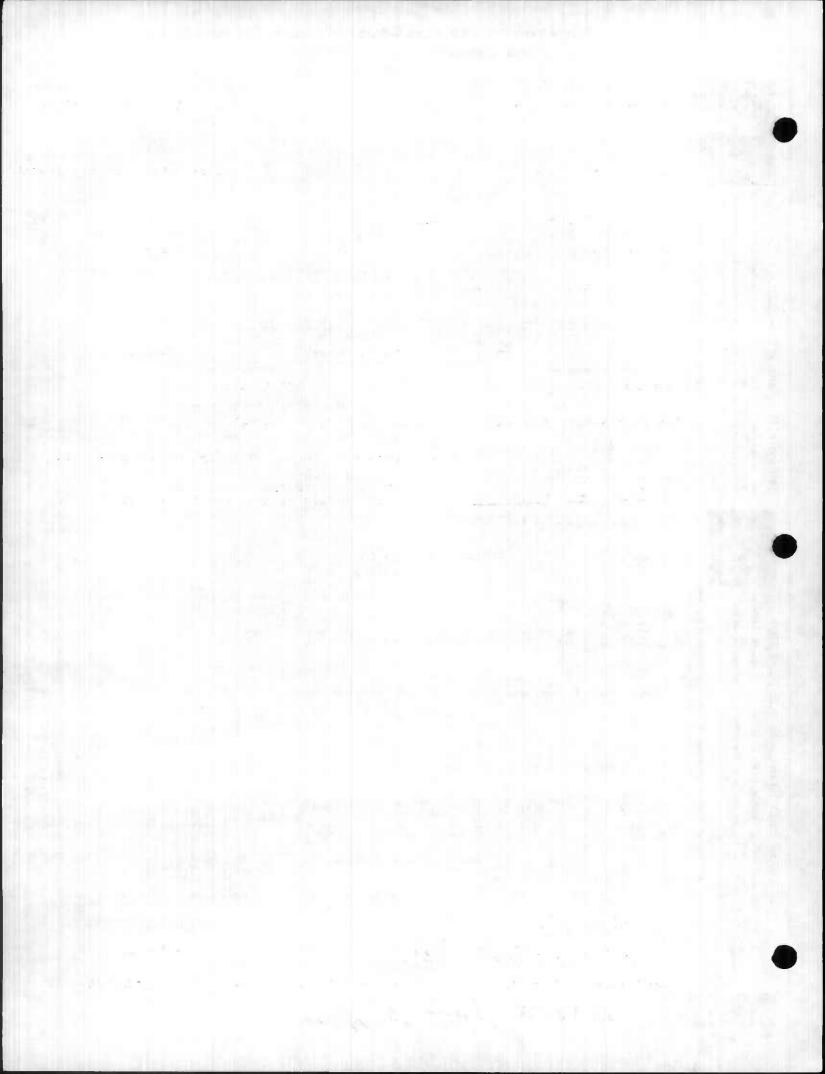
To the Funeral Director: After this certifica completely filled in by the funeral director; g Be 25. Wes casa raferred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Wursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28b. Time of Injury 28a. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 26d. Describe how injury occurred 28c. Injury at Work? 1 BNaturai 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 ☐ Suicide Place of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, deta and piace, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and mannar steted. 29a. Certifier Medical 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year) D19667 we and 7-28-89, belland 30. Nema and address of person who completed cause of death (Itam 23e) (Type, Print) Dr. Michael Schwartz 5517 Ritchie Highway Glen Burnie, Maryland 31. Date filed (Month, Dey, Year) 32 Registrer's Signetura State JUL 2 8 1999 Registrar oacks



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 17, **Physician** 1999 William Lester 1:29 pm July Sailer /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 9410 1st Street Laurel Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Sep. 19, 1937 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1₩ M 2□ F Pennsylavania 191-28-9773 61 Yrs. **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or itema 23a or 28a-f show other treumatic event, the Modical Examinational be notified at 1□ Yes 2□No Director Md. Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9410 1st Street 20723 U.S.A. Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other treumatic event, its Mod cal Exercise page. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify. White by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 2 years Elementary/Secondary (0-12) Systems Analyst Food/Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sigmund Sailer Nell Cullen 19a. tnformant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Chanphen Sailer / spouse 9410 1st Street Laurel, Maryland 20a. Method of Disposition
1 Durial 2 Ocemation 3 Removal from State 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 7/19/99 Catonsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerai Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. (The 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rvat Retweer Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Metastatic Lung Cancer 2 years Examiner Due to (or es a consequença of) Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): the death certificete be exec Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 3 1♥ Yee 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 9 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed peen page 2 cartificata has 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: Other: 4☐ Nursing Home 5 Hesidenca 8 ☐ Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at After Hospital or Attending 1 Naturel 5 Pending investigation aftar death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 Homicide 24 hours 29a. Certifie the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical Certifying, Physician In the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signatury 29c. License number 29d. Date signed (Month, Day, Year) D 08754 July 19, 1999 26 cause of death (ttem 23a) (Type, Print) Thomas Bensinger, M.D. 7525 Greenway Center Drive Suite 205 Greenbelt, Md. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JUL 1 9 1999 Registrar



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State of Maryland / Department of Health and Mental Hygiene 9 9 9 9 9 5

				Certificate	e or t	Jealli		Re	g. No.			
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/Medical	4e Facility Name (If not institution	egina S. Tip			14	h City To	wn or Local	JULY 2	5,1999 4c. County	of Doeth	1825	
Examiner	St Agnes	Healthco				D.	tim		None			
Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birth	nday) If Under Months	1 Year Deys	If Under : Hours	Min.	(Month, Day,			ice (State or For	
Director	220-05-3695 Usuel Residence of Decedent		84	13.			D	ec 28,	1914	Mary	rland	
show of	10e. State 10b. Count	у	10c. City, Town	or Location						10	d. Inside City Lin	
a or 28a-f show the notified at Director		vard	Elk	ridge							1 ☐ Yes 2 ☑	
r items 23a or 28a-fs irrer must be notified Funeral Director	10e. Street end Number 6084 Old Washin	naton Road		10f. Zip		.075		10	g. Citizen of V United			
ms 23	11. Meritel Status	12. Wes Deceder	t Ever in U,S.	13. Was Deced			gin? (Specif	y Yes or No-	14. Rac	e - America	n Indien,	
0 5	1 Never Married 2 Me 3 Widowed 4 Divorce	If Yes, Give	₩No	If Yes, spec		n, Mexicen Specify:	, Puerto Ric	en, etc.)	Specify	k, White, e		
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a se a	17. Father's Name (First, Middle Frank J. Miller						,		Middle, Maiden Sumame) Otten			
DEE	19e. Informant's Name/Relation	ship (Type, Print)	19b.						sa M. Otten ural Route Number, City or Town, State, Zip Code)			
= 21 -	Mary Ethel Koor	ntz/Sister	38	3850 Old Columbia Pik					tt City	, MD	21043	
of Heal	20a. Method of Disposition		20b. Place of	Db. Place of Disposition (Name of cemetery, crematory or other place)					Oc. Location -			
	1 🖾 Burial 2 🗆 Cremetion 4 🗆 Donation 5 🗆 Other (8	ridge C			7-	29-99 I	Elkridg	re, Ma	ryland	
Department important: f any Injury o pace.	21. Signature of Funeral Service	Licensee	0.1.		H. W	itzke	's Fa	mily Fu				
	orane a	(ochio a	unic	4112 0	ld C	olumb	ia Ri	ke Ell:	icott C	ity,	MD 2104 Approximate	
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hysician /Medical xaminer ਹੋ	Immediate Cause (Final disease or condition resulting in deeth)	a. Her	Due to (or es e c	lyo (a)	ede	nl	V.	nfur	ction		30 mini	
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is certificate hes to director, page 2 s To Be Comple	25. Wes cese referred to medice examiner?			patient 3□ DC	Oth Oth	er _		1 □ Y6	s 2)XNO	of d	pletion of cause eath? Yes 2700	
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within 24 hours after death. To the Funeral Director: After this certificate has to completely filled in by the funeral director, page 2 s Medical Certification: To Be Completely filled in the complete service of the com	examiner? 1 Yes 2 Yo 27. Mapner of Death 1 Natural 5 Pend inves 3 Suicide 6 Could deter 29a. Certifier (Check only one) 29b. Signature and title of certifications	Hospitel: 1 Inpa 1 Inpa 28a. Date of In (Month, D 28e. Place of I building. 1 Inpa 28e. Place of I building. 1 Examinar: On the basis and manners	lient 2 ER/Out jury ay Year) 28b. Ti in njury - At home, far atc. (Specify) t of my knowledge, of examinetion end stated. death (Item 23a) (I	me of jury M 2 m, street, factory death occurred /or Investigation.	8c. Injun Wor 1 v, office at the tin , in my o	er: 4 Nu y at k? Yes 2 ne, date an pinion, dea	No 28i	1 Ye Check only one 5 Reside d. Describe ho Location (Str. City or Town d due to the ca et the time, de	nce 6 Oth w Injury occur reet and Numb, State)	of d 1 □ or (Specify, red over or Rural anner as sta and due to d (Month, L	roletion of cause eath? Yes 20000 Route Number, ated. the cause(s)	

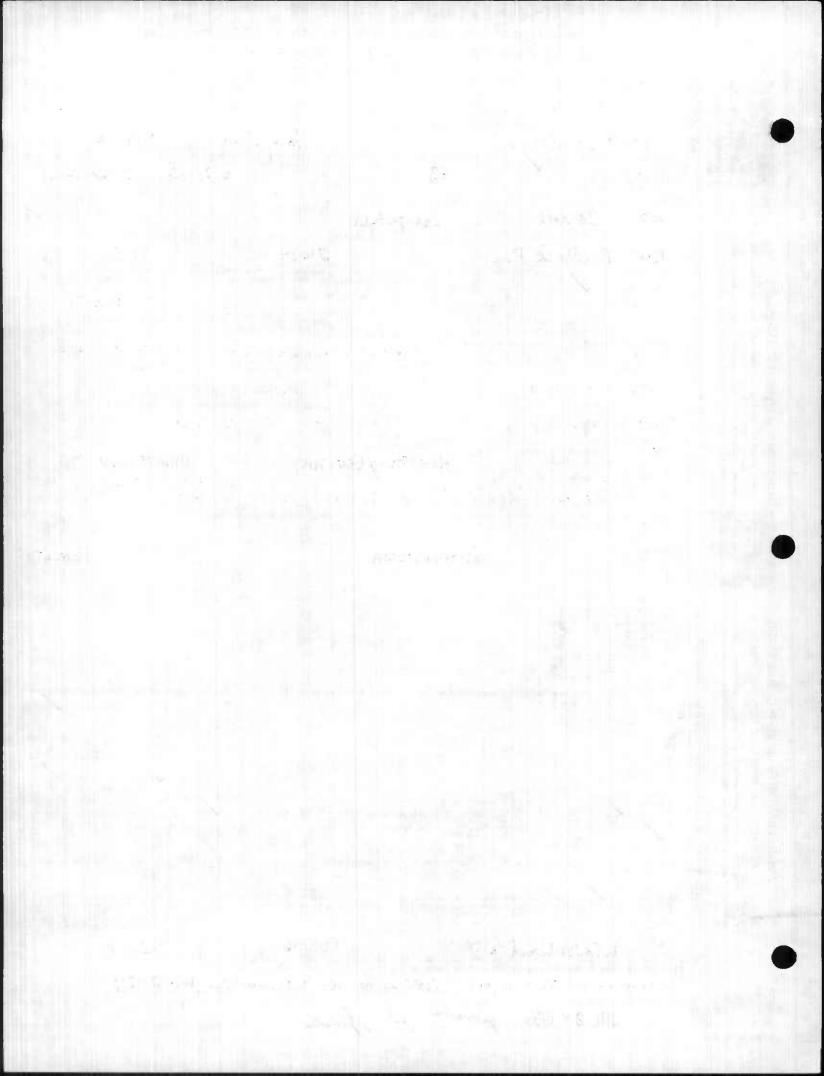
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Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 3. Tima of Death 1. Decedent's Nema (First, Middla, Last) **Physician** 24, July Charles Edwin Wagner 1999 11:15 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Brodbeck Rd CARROLL 1347 If Under 24 Hrs. 8. Date Hours Min. (Mo If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 8. Sex 1 M 2 □ F 7. Aga (In yrs. lest birthdey) 8. Data of Birth (Month, Dey, Year) **Funeral** Months Days Hours 63 Yrs. **Director** Pennsylvania 217-30-7254 Usual Residenca of Decedant with the Maryland permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiana. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be northed at 000. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll 1 Yes 2 Wio Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Brodbeck U.S. 1347 21074 Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stetus Black, White, etc. 1 Nevar Married 2 Merried I □ Yes 2☒ No If Yas, Giva Year or Detes: Baltimore, Maryland 21215-0020 1 Yes 2♥ No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Joseph A. Banks Sewing Machine Mechanic 9 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fathar's Neme (First, Middle, Last) Norman A. Wildasin Pauline Wagner 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Nancy Wagner, wife 1347 Brodbeck Rd, Hampstead, Md 21074 20a. Methed of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HAMPSTEAD CEMETERY 7/28 HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee 22. Name and Addrass of Facility Eline Funeral Home 934 South Main St, Hampstead, Md 21074 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final /wedical GLIOBLASTOMA 6 MONTHS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit requires that the death cartificate be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in daeth) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the t Due to (or es a conseguança of): usa signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Vinknown by 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24e. Wes an eutopsy certificata has t lirector, paga 2 s 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 ☑ No or Attending Physician: director, 25. Wes case referred to medical axaminar? 26. Place of Deeth (Check only-one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Dete of Injury (Month, Day Year) funeral 27. Menper of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. invastigetion 2 Accidant after deat Director: 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide hours 8 Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completaly fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifiar 29c. License number 29d. Data signed (Month, Dev. Year) D08516 7-26-99 WEWordward 95 Carroll Street 30. Name and eddress of person who completed dause of deeth (Item 23a) (Type, Print) WILLIAM & WOODWARD MD CARROLL HOSPICE. WESTMINSTER MD 21157 31. Data filed (Month, Dey, Year) 32. Registrar's Signature Registrar 2 8 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Day **Physician** William Glen Warner July 26, 1999 10:15 am /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 16605 Trenton Road Upperco Baltimore 5. Social Sacurity Number If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) NOV 25, 1952 7. Aga (In vrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours Min. 1 € M 2 □ F 217-60-0736 Yrs. 46 Director Pennsylvania Usual Rasidance of Decedant with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, its Medical Examiner mast be notified at 1 ☐ Yas &☐ No Maryland Baltimore Director Upperco 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16605 Trenton Road 21155 USA death y Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Raca - American Indian, Black, Whita, atc. 11 Maritel Status permit. Peges 1 and 2 should be filed within 72 hours effer. Department of Health end Mental Hygiene. I important: If item 27 is marked other than "natural", or ther any injury or other traumatic evant. 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Detes: 1 Navar Married 27 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: White þ 3 Widowad 4 Divorced Completed 18a. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada complated) Baltimore County Collega (1-4or 5+) Elementary/Secondary (0-12) Fire Department Fireman 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Name (First, Middle, Last) William Glen Warner Grace Marie Fishpaw 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joanne Warner, wife 16605 Trenton Rd, Upperco, Md 21155 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Data 1 Buriai 2 Cramation 3 Ramovai from Stata Upperco, MD 4 ☐ Donation 5 ☐ Othar (Specify) Trenton Cemetery 7/28 21. Signeture of Fugeral Service Licanses 22. Nama end Address of Facility Eline Funeral Home la. e 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examiner ician end burial-transit Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disease or Injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of): physician the buria Box 68760. Physician/Medical Dua to (or as a consaquance of): 65 980 P.O. 23b. Did tobacco use contribute to the ceuse of deeth? ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 Probably 4 Unknown 1 Yes signed t Division of Vital Records. p 24b. Wera autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? paga 2 certificate has 1 ☐ Yas 2 ☐ No or Attending Physician: director. 25. Was casa rafarrad to medical examiner? 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 22 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury et Work? After Natural 5 Panding 1 Yas 2 No death. Invastigation 2 Accident after deat 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicide filled in 24 hours a Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the contro 29a. Cartifiar Medical completaly (Check only one) ner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. within 2 To the 29b. Signature and title of certifie 29c. Licanse number 29d. Date signed (Month, Day, Year) Fersa Hanyoling Teresa ith (Item 23a) (Type, Print) 30. Nama and addrass-of persor 96 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUL 2 8 1999 Registrar

Ple

	Please					k. Assure A		_	ble.	5288
				Certifi	cate o	f Death	R	eg. No.		. 0 6 0 0
1. Decedent's Nam	ne (First, Middle, Las	(1)					2. Date of Dear	th		3. Time of Deeth
Franc	es Eliz	abeth W	right				July	24	1999	6:00AM
4a Facility Name (If not institution, give	street and number)				4b. City, Town, or I	Location of Death	4c. County	of Death	
Look Ab	out Manor					Westmi	nster	Ca	arrol	.1
5. Social Security P 212-09-4		9x	e (In yrs. last bir 82		under 1 Ye nths Day		8. Date of Birth (Month, Day Feb. 5,	1917	9. Birthi Cou Vir	plece (State or Foreign ntry) 'Sinia
Usual Residence of	f Decedent 10b, County		10c. City, Tow	n or Locatio	n				1.	10d. Inside City Limits
										1 ☐ Yes 2 ☒ No
Maryland	Carroll		N	ew Wir		No.		Do Citizen of	Affron Cour	
10e. Street and Nu				10	of. Zip Code			Og. Citizen of		ntry r
	Marston Rd		Francis II C	10 11/00 1		1776	nanih. Van as Na		S.A.	can Indien,
11. Marital Status	ind OF Marriad	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \)		If Yes	s, specify C	f Hispanic Origin? (S uban, Mexican, Puert	o Rican, etc.)		ck, White,	
3 🖾 Widowed	ried 2 Merried 4 Divorced	If Yes, Give Yeer or Detes:				lo Specify:			Whi	
(Spe	 Decedent's Ed cify only highest grade 		16a.	Decedent's (Give kind	of work dor	ne during most of wor	king	16b. Kind of B	usiness/in	dustry
Elementary/Sec	ondary (0-12)	College (1-4or	5+)	IITO. DO N	OT use ret	stress	100	cloth	nino	CO
17. Father's Name	(First, Middle, Last)				Deam		ne (First, Middle, i			
	N. Smith						lizabeth			
	lame/Relationship (7			Mailing Ad		eet and Number or Ru		r, City or Town	State, Zij	
4 Donation 21. Signature of F	□ Cremation 3 🔊 5 □ Other (Specify uneral Service Licen	O. War	St. St	cephen 22. Nar 310	y or other points Ba me and Add	ptist Cem dress of Facilitar ch St. N	7/27/99 tzler Fur Tew Winds	or, MD	Co.,	VA
23a. Part1. Enter shock, or her	the disease, or comp art failure. List only o	olications that cau	ne.	not enter the	e mode of o	tylng, such as cardiad	or respiretory arr	est,		Approximate Interval Between Onset and Deeth
fmmediate Ceuse disease or condition resulting in death)	on	a Prob	Mu Su	1515	0					3 dry s
		b. Vesu	W CO	Consequence	15か	LX.				Zwks.
Sequentially fist or if any, leading to it cause. Enter Und Cause (Disease or	nmediate erlying r injury	. du	MIL	(NC	m+	neum.			9 m	yers
that Initiated event resulting in death)	Last	An	Due to (or as a	consequenc	a of):					0
		d. CLV	neut	R						yuns.
1	ticant conditions co		out not resulting in	n the under	ying cause	given in Part I.	23b. Did to	_	ontribute t	to the cause of seath?
1han	vssin otyvoi	116100					24a, Was e	en autopsy med?	a	Vere autopsy findings vailable prior to
14.11	ologool	Oct you					1 U Y	es 2tho	of	ompletion of cause death?
25. Was case rete	rred to medicai					26. Place of De	ath (Check only or		/	A su stimm
examiner? 1 Yes 2 27. Manner of Dea 1 Natural	5 Pending	Hospital: 1 ☐ Inpati 28a. Date of Inju (Month, Da	iry 28b.	Time of Injury	28c. Ir	Other: 4 Nursing Injury at Nork?	lome 5 ☐ Resid	ence 6 Ott	ner (Speci rred	ity) divinity)
2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Placa of In	jury - At home, fa c. (Specify)	ırm, street, f		Yes 2 No	28f. Location (S City or Tow	itreet end Num n, State)	ber or Rui	ral Route Number,
29a. Certifier (Check of one)	1 ☐ Certifying Phy 2 ☐ Medical Exam	veician: To the best liner: On the basis o end manner st	f examination an	e, death occ d/or investig	urred at the	e time, date and place y opinion, death occu	a, and due to the durred at the time, o	ause(s) and m	anner as	stated. to the cause(s)

within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed Division of Vital Records, P.O. Box 68760,

Certification: To Be Completed by Physician/Medical Examiner

Medicai

Physician

/Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

Department of Health and Mental Hyglene. Instural; or items 23s or 28s-f show important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical

Examiner

Director

Funeral

þ

Completed

Be

2

29b. Signature

Philip

State Registrar

JUL 2 9 1999

J

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Airport Drive

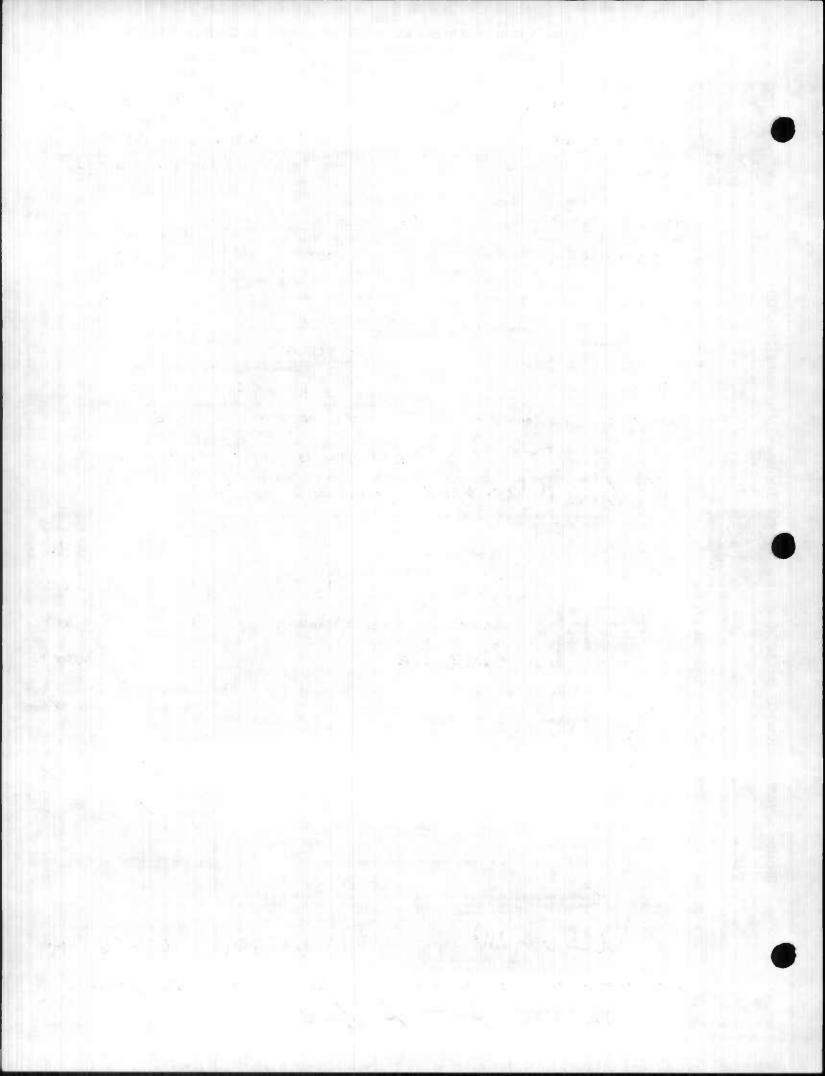
MD

29c. License number

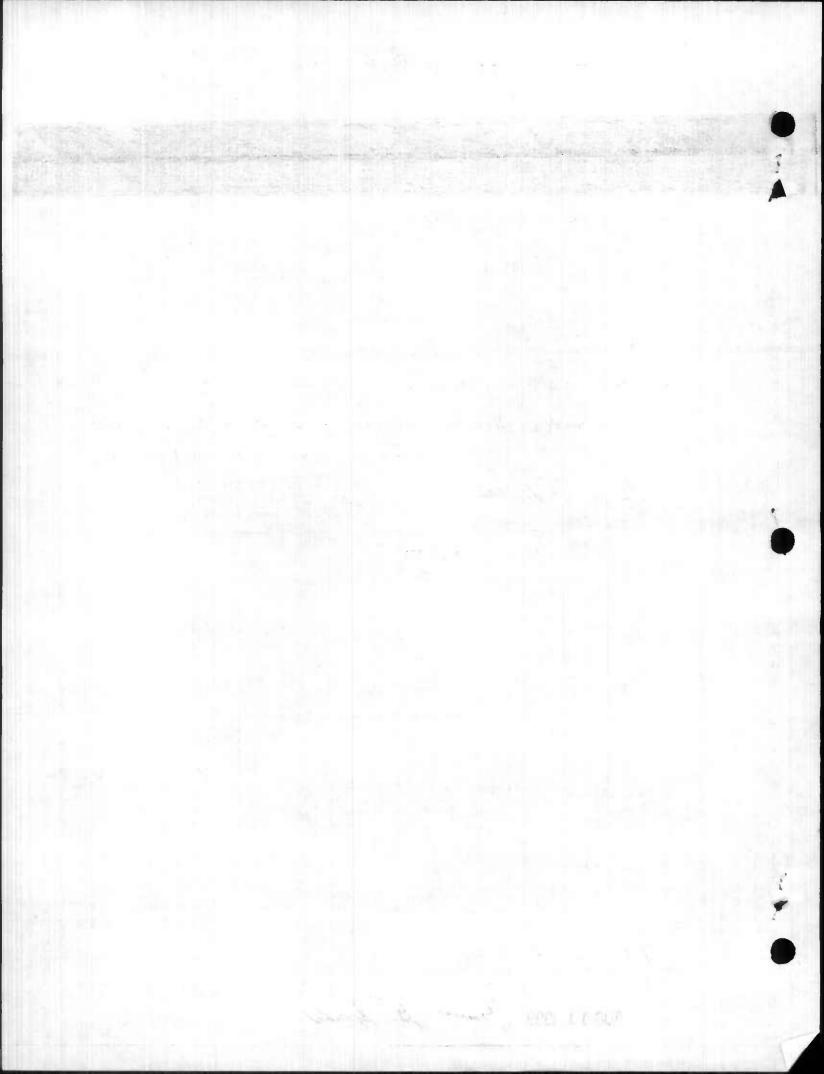
21157

29d. Date signed (Month, Dey, Year)

Suite 34 Westminster, MD

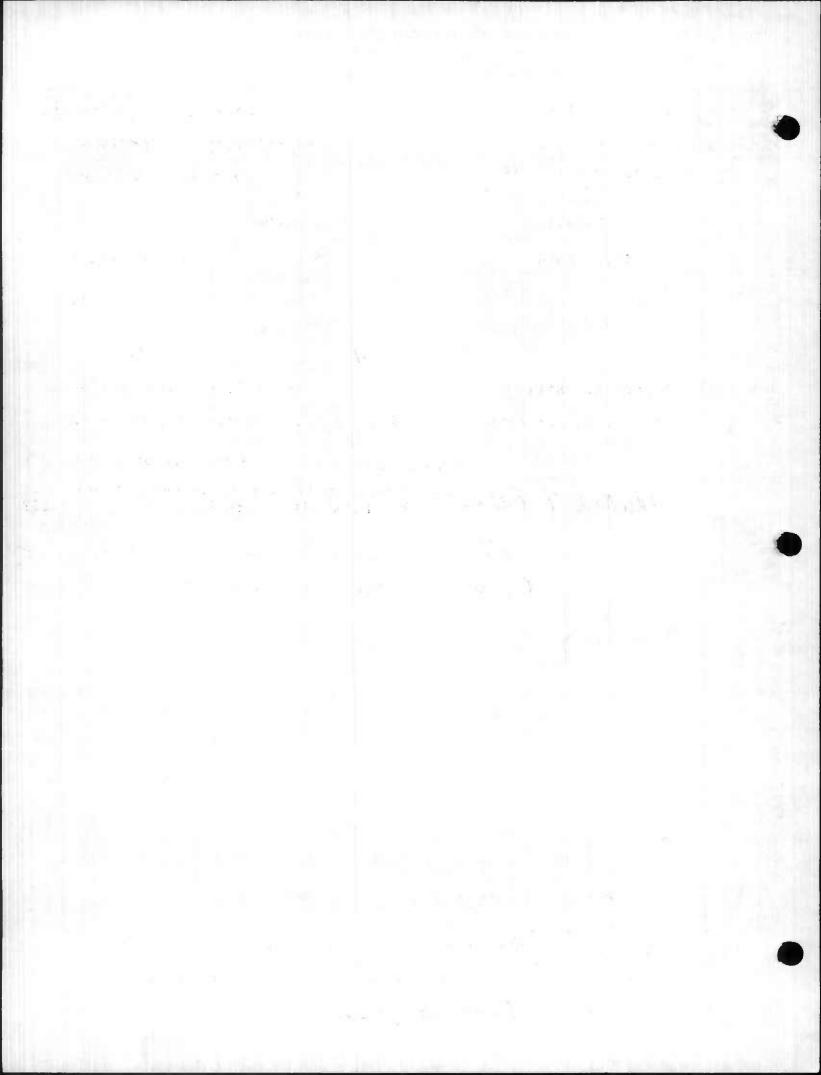


		State of M: #23 PART I,	27 PE	R Cei	tifica	te of	Death						
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/Medical Examiner	4a Fecility Neme (If not institution, g								cation of Death	4c. County	of Death		
	5101 Henderson B				Willad	er 1 Yeer	Temp1				ce Geo		
Funeral Director	5. Sociel Security Number 6. 220-96-6601 Usual Residence of Decedent	Sex 7. Aç 1 ☑ M 2 ☐ F	18	last birthday) Yrs.	Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day, July 22		9. Birthpli Count Washi	ace (State of ry) ng ton	
anyland show id.at	10a. Stete 10b. County		10c. City	, Town or Lo	cation						10	d. Inside C	Ity Limits
with the Maryla or 28s-f sho be notified at Director	Maryland Prince	George's	Tem	ple Hi	1								2 1 No
	10e. Street and Number 5101 Henderson	Rd			10f. Z	ip Code	0748		1	U.S.A		ry?	
her death w there 23s siner must b Funeral I	11. Meritel Stetus	12. Wes Decedent	Ever In U,	S. 13.)	Nes Dec			in? (Spe	cify Yes or No- Rican, etc.)	14. Rac	e - America		
by Exa	1 🖾 Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Yeer or Detes:		1			Specify:	, Puerto	Hican, etc.)		ck, White, e y: Whit		
disal	15. Decedent's 6 (Specify only highest go			16a. Deced	lent's Us kind of w	uel Occup	ation during most	of worki	ng	16b. Kind of B	usiness/Ind	ustry	
or the Medical r, the Medical Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		uder.		1)			N/A			
avent, 1 Be Cc	17. Father's Neme (First, Middle, Las	it)					18. Mother	r's Neme	(First, Middle, I		ne)		
To B	Benedict Franci	s Walton, S	Sr.				Alma	Mar	ie Yates	3			
de me	19e. Informent's Neme/Relationship				-				l Route Number				
Health em 27 ther tr	Benedict F. Walte	on, Sr./Fa	_	5101			n Rd.,	Ter	nple Hil	1s, MD			
V CF CF	1A Burlal 2 Cremation 3 4 Donation 5 Other (Spec		C	urrect	natory or	other place		8/6	5/1999			wit, Otolo	
orten ingli	21. Signature of Funeral Service Lice	onena.	1-100						eral Hom				
THE ST	Dear a	1/alas	/						Oxon Hi			5	
aminer	disease or condition resulting in deeth)	a		RDITIS res a conseq	uenca of):							
hysician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	0.	Due to (or	es e conseq	uence of):					1		
0 8 9	that initiated avents resulting in death) Last	d	Due to (or	es a conseq	uence of):						T-	
the atter thed for ysician	Pert II. Other significant conditions	contributing to death b	ut not resu	alting In the ur	nderlying	cause giv	en in Pert I.		23b. Did to	bacco uss co	ntribute to	the causs	of death?
be detached for use by Physician/N									1 🗆 Y	ss 2 No	3 Prob	ably 4	Pinknown
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page 2									10 Y	es 2 No	160	Yes 2] No
ertifik Be	25. Wes case referred to medical examiner?	Marshall				l ou		of Death	(Check only on	ie)			
를 다 다	Y⊠ Yes 2 No 27. Manner of Death 1 ☑ Neturel 5 Pending	Hospitel: 1 Inpatie 28a. Dete of Inju (Month, De		ER/Outpatien 28b. Time of Injury		28c. Injur Wor	4LI NUI		ne Popeside 28d. Describe h)	
at Director: After the director: After the director by the funeral Certification:	2 Accident Investigetic 3 Suicide 6 Could not l 4 Homicide determined	be One Place of Ini	ury - At ho	me, ferm, str			163 2		28f. Location (SI City or Town		ber or Rural	Route Nun	nber,
Medical Ce	29e. Certifier (Check only one) 1 Certifying P	hysician: To the best of miner: On the basis of and menner sto	examineti	vledge, deeth ion and/or inv	occurre	d et the tin n, in my o	ne, dete end pinion, deat	d place, s	and due to the ca	ause(s) and m ate end placa,	enner as sta and dua to	ated. the cause(s	5)
Z Mehin	29b. Signeture and title of certifier	1.1.			2	9c. Licens	e number		2	9d. Date signe	d (Month, L	Day, Year)	
4. 4.	76.01	1 Vina 1	4			O.C.	M.E.			August	3, 19	999	
12	1 Medeure	11 00											
1/2	30. Nama and address of person who	completed cause of d	eeth (Item	23a) (Type,					imore, M				



State of Maryland / Department of Health and Mental Hygiene

					(Certifica	ate of	Death		Reg. No.	25	290
•	Div1-1		1. Decedant's Nama (First, Middla, Last)						2. Data of Dec	eth		Tima of Death
ı	Physici /Medi		Sue Ann White						July	27. 19	Year	7:45PM
3	Examir		4a. Facility Nama (If not institution, giva st	reet and number)				4b. City, Town, or				F-4-0FM
			2718 Guard Road					Federa	Isbura	Ca	aroline	P
Г	Funerai	Г	5. Social Security Number 6. Sex	7. Aga (In yrs		A d made	dar 1 Yaar S Days	If Undar 24 Hrs	8. Data of Birt			(Stata or Foreign
	Director		551-27-1376 Usual Rasidance of Decedent	M 200 F	33 Yr	s.	Juys	TIOUS WILL	3/15/6	56	Califo	rnia
	yland mow		10a. Stata 10b. County	10c. C	ity, Town o	or Location					10d. I	nsida City Limits
	ter death with the Marylan items 23a or 28a-f show net mast be notified at	ţ	MD Carolin	6			Fed	deralsb	ura		1	I □ Yas 2 No
	7 28	Director	10e. Street and Number			10f. 2	Zip Coda			10g. Citizan of	What Country?	
	h wit	O I	2718 Guard Road				21	1632		United	State	2.9
	dead dead	Funeraí		2. Was Decedant Evar in I	J,S.	13. Was Dec		Hispanic Origin? (S ean, Maxican, Puar			ce - American Ir	
Maryland 21215-0020	n 72 hours efter death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	þ	1 Navar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:			2 No		to Hican, atc.)	Specif	ock, Whita, etc. by: Whi	te
Ö	2 ho	Completed	15. Dacedant's Educa	ation	16e. D	ecedant's U	suai Occu	pation		16b. Kind of B	usinass/Industr	у
2	S .	ge	(Specify only highast grada Elementery/Secondery (0-12)	College (1-4or 5+)	- (6	fa. DO NOT	vork dona usa retire	during most of wo	rking			
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nd	0 = 0 5	Be	17. Fathar's Nema (First, Middle, Last)						ma (First, Middla,			
yla		2	Robert N. Whit	е				Marth	a E. Fe	rgusor	n White	9
Var	2 9 8		19e. Informent's Name/Ralationship (Type			_		and Number or R				
	C TO N L		Martha E. White/					RD. Fee		urg, r	10 21	632
Baltimore,			20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ra		Place of D camatary,	isposition (A cramatory o	lama of r othar pla	ice)	Date		- City or Town,	
E	nit. Pag partment cortant: injury ca.		4 ☐ Donation 5 ☐ Othar (Specify)		thel	Ceme	eter	y	7/28	Vr.Fed	eralsb	urg,MD
3all	permit. Page Department of Important: If any injury or once.		21. Signature of Funaral Sarvica Licansas					ass of Facility	- Calcar		w = 1 11 =	
ш	20 E E 8		Yhichael 7- 23a. Parti. Entar tha disaasa, or complice	EXKRU	-			-Hawkin				
	Physician /Medical Examiner		shock, or heart failure. List only one Immediate Ceuse (Final disaese or condition resulting in deeth) a.	EISENDUE to CONGON	or as a co	NCE nsequence o	12 S	Syno	>Rumë		Ons	arvel Batween sat and Death
ox 68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	n/Medical Examiner	Saquantially list conditions, if any, leading to Immadiate causa. Enter Underfying Cause (Disease or injury that Initiated evants rasulting in death) Last	Due to (ores e cor	nsequence of	f):	CULAR)	DEPTAL	Dofe	er eng	120 46
	deat	sicia	Part II. Other significant conditions contr	ibuting to death but not ra	sulting in th	na undarivino	causa oi	ven in Part I.	23b. Did t	obacco usa co	ontributa to the	cause of death?
P.O. Box	et the by th	Physician/	PULLONARY			, , , , , ,				Yes 2 No		y 4 □ Unknown
	gned be de	by		0.162	<i>y</i> , –							
Records,	aw requires that the death cet s been signed by the ettendir 2 should be detached for use	Completed							24e. Wes parfo	an autopsy med?	avallabi	utopsy findings la prior to ition of cause h?
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Ta	rtifica ctor, p	Bec	25. Was case referred to medical					28. Plece of De	eth (Chack only o	na)		
>	Physician: r this certific rrai director,	To	examinar? 1 ☐ Yas 2 ☑ No Ho	spital: 1 Inpatiant 2	ER/Outpa	atient 3 1	DOA Ot	har: 4□ Nursing ł			har (Specify)	
0	g Ph er th		27. Mannar of Deeth	28a. Date of Injury (Month, Day Year)	28b. Tim	e of	28c. Inju Wo		28d. Dascribe I			
0	Attending ar death. ector: Atter by the fune	atlo	1 Natural 5 ☐ Panding 2 ☐ Accidant Invastigation	(MOIIII, Day Teal)	Inju	M		Yas 2□No				
Division of Vital	s after de il Directo d in by th	Certification:	3 Sulcida 6 Could not ba 4 Homicide datarmined	28a. Place of Injury - At h building, etc. (Speci	noma, farm	, straat, fact	ory, office		28f. Location (S City or Tox		ber or Rural Rol	uta Number,
	To the Hospital or Attending Physician: The law within 24 brouts after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Cartifier (Check only one) 12 Certifying Physic 2 Medical Examina	cian: To the best of my known: On the besis of examination and mannar stated.	owledge, dation and/o	aath occurre or invastigetio	ed at the ti	ma, data and piace opinion, deeth occu	e, and dua to tha ourred at tha tima, o	causa(s) and m data and place,	anner as stated and dua to tha	cause(s)
	Withir To th	Me	29b. Signature and the of certifier	0 /	7	2		sa number			ed (Month, Day,	
			1200	tucke	- N		1/2	3562		07:	28.99	7
			30. Nama and addrass of parson who com	plated cause of death (the	m 23a) /Tu	ne Print)					-	
			SCOTT D. FRIEDMA	N,M,O.	403	Marve	1 C	t. East	on. Mar	vland	2160	1
	Sta	te	31. Data filed (Month, Day, Year)	32. Ragistrar's Sign		1			,			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 26, Hubert Lee Warren 1999 1509 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Talbot Easton | H Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Jan 16,1934 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Yrs. Director 214 30 8362 65 Arkansas Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mentel Hyglene. Important: if Item 27 ie marked other than "naturel", or items 23s or 28s-f ahow with Julyry or other traumatic event, the Madical Examiner must be notified at pines. 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Caroline Greensboro 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Cedar Lane 21639 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 Married Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Town of Greensboro 11 Maintenance Department 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Gus Nelson Warren Laura Drake 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Cedar Lane Greensboro Maryland 21639 Jeanne Warren Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 7-29-99 Greensboro, Maryland 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility Fleegle & Helfenbein Funeral Home PA PO Box 160 Greensboro,

23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Greensboro, Maryland 21639 Approximete Intervel Between Onset and Deeth Physician MYOCARDIAL INFARCTION /Medical Immediete Cause (Finel disease or condition resulting in death) HOURS Examiner Examiner ettending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? ed by the detached MELLITUS signed by t 1 Yes 2 No 3 Probably 4 Unknown IABETES þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? 1 Yes 2 1 Yes 2 No Be 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA this this funeral 27. Manner of Death ne Hospital or Attending Pi in 24 hours after death. The Funeral Director: After I spletely filled in by the funer. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After t Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide The state of the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

The state of the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

The state of the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7-26 - 99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Rodreguez MD 403 Marvel Ct 21601 Easton, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

JUL 2 8 1999

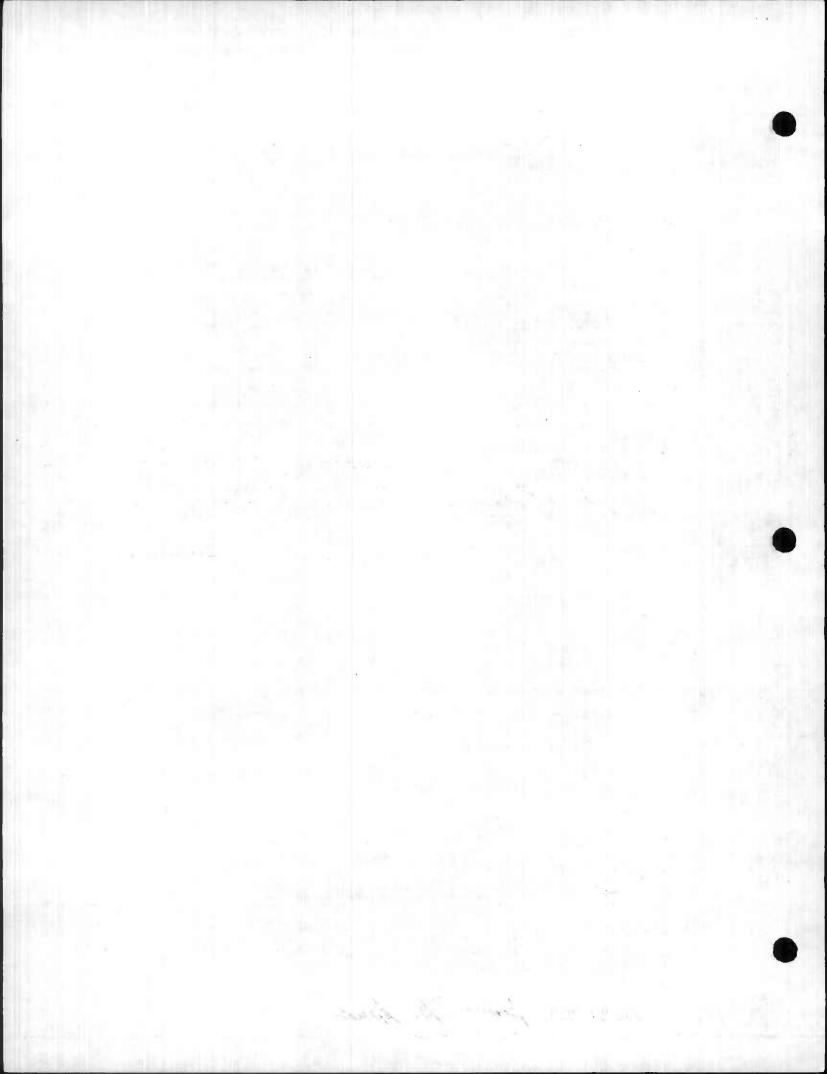
Baitimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

Hubert Warren

parks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Name (First Middle Last. 2. Date of Death 3. Time of Death **Physician** July 26, 0846 AM 1999 James I. Wheatley /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cecil VA Maryland Health Care System Perry Point If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number Birthpleca (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Deys Hours M 20 F Yrs Nov 19, 1923 Director 216-14-8481 Maryland Usual Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. inaide City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Howard Ellicott City å 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 4109 Old Columbia Pike 21043 United States "natural", or items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Wes 2 □ No If Yes, Give Year or Dates 1943-45 Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yea 2X No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry should be filed within Elementary/Secondary (0-12) Collega (1-4or 5+) Hygiene. Display Work Liquor 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental Irvin Wheatlev Adelaide Mears 19a. Informant'a Name/Ralationship (Type, Print) 19b. Meiling Addresa (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Pages 1 and 2 s ment of Health ar Department of Health Important: If Item 27 4109 Old Columbia Pike Ellicott City, MD 21043 Ruth C. Wheatley/Wife Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ò 7-29-99 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadowridge Cemetery 22. Name end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 21. Signeture of Funerel Service Licenses Dan a 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Entar the disease, or complications that caused tive death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in daath) /Medical 3 Days Pneumonia **Examiner** Due to (or as a consequanca of): Examiner attending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury Due to (or as a consequence of): Box 68760. Physician/Medical thet initieted evants resulting in death) Last Due to (or es e consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure Division of Vital Records, by 24b. Were autopsy findings available prior to complation of causa of death? 24a. Waa an autopsy performed? Completed peed Alzheimer's Disease certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No After this certifical funeral director, I or Attending Physician: 25. Was casa rafarrad to medical examiner? Be 26. Piace of Death (Chack only one) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☑ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred 5 Pending 1 CN Natural 1 Yes 2 No death. investigation 2 Accidant 24 hours efter deat Funerel Director: 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as atatad.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner statad. edicai 29a. Certifian (Check only within 2 one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 0 -Sodhi D42014 July 26, 1999 5 30. Nama and addrass of person who completed cause of death (item 23a) (Type, Print)

Surinderpal Sodhi, M.D., VA Maryland Health Care System, Perry Point, MD 21902

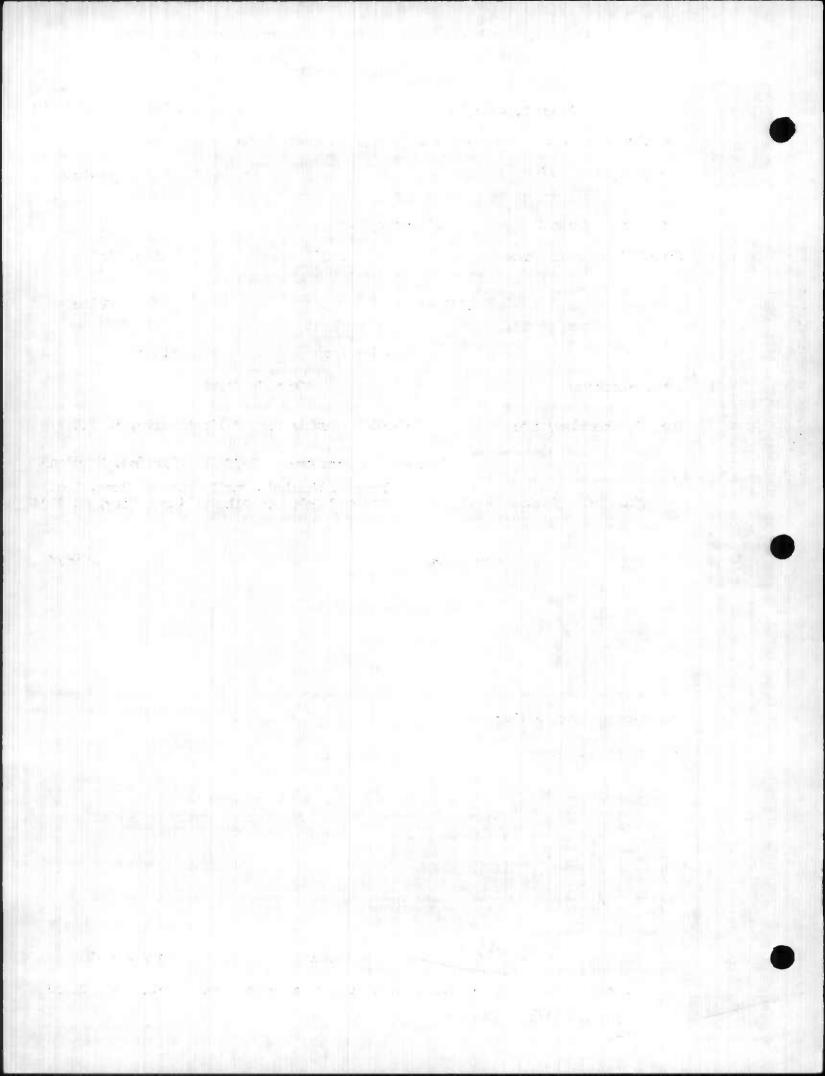
32. Registrar's Signatura

State Registrar

31. Data filed (Month, Day, Year)

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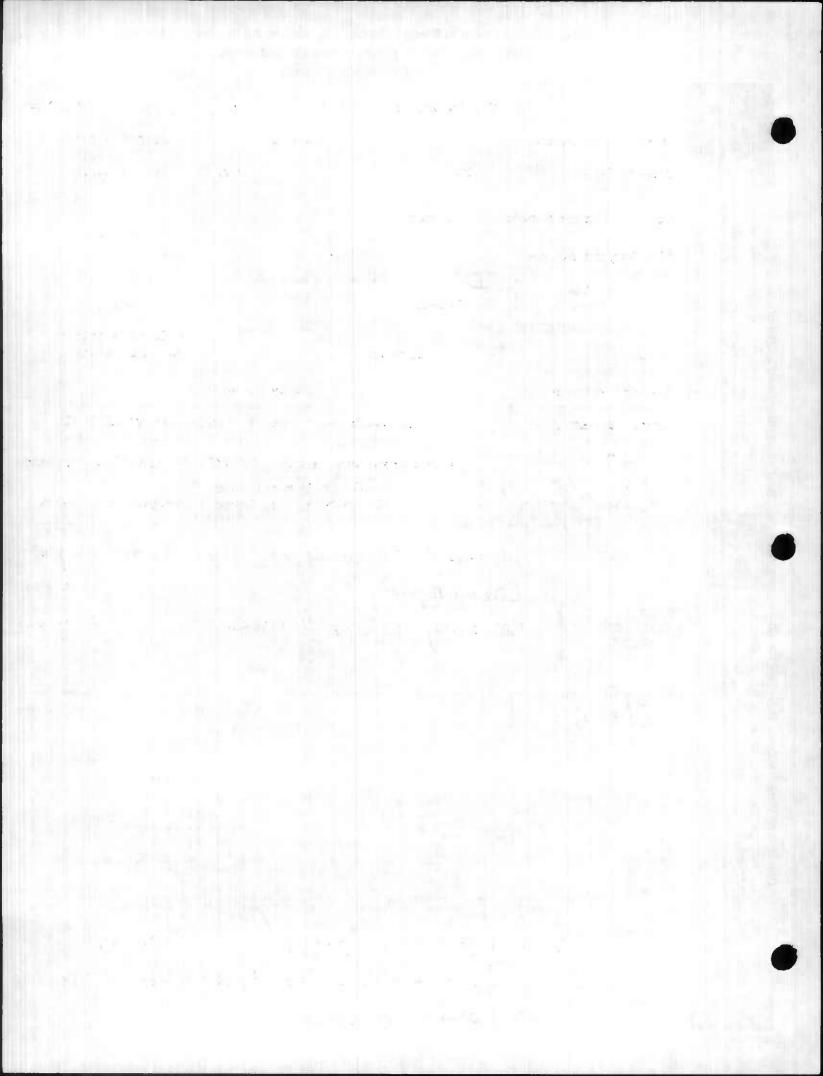
KNOWN TO PHYSICIAN:



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** Calvin Ouentin Walters 6:00 am 14, 1999 July /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 505 Compton Avenue Laurel Prince George If Under 1 Year | If Under 24 Hrs. 8. Dele of Birth Month, Day, Year) Aug 09, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1X M 2□ F 213-09-7980 79 Yrs. Director Maryland Usual Residence of Decedent the Meryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ¥ Yes 2 □ No MD Prince George Laurel Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 7 is marked other than "naturel", or items 23s or traumatic event, the Madical Examiner must be a 20707 505 Compton Avenue USA Funeral hours after deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11 Marital Sletus Bleck, White, etc. 1 N Yes 2 No
If Yes, Give
Year or Dates: 1941-45 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Pages 1 and 2 should be filed within 72 hour of Health and Mental Hygiene. Int: If item 27 is marked other than "net Federal Aviation Elementery/Secondery (0-12) College (1-4or 5+) Grade 9 Administration Foreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Maude S. Hackley Sanford Walters 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 12 South Paula Street, Laurel, Maryland 20724 Larry Walters /son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State important: If its eny injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 7/17/99 Catonsville, Maryland Metro Crematory, Inc. 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the display or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feither only one cause on each line. Approximate Interval Between Onset and Death Physician . Advanced atheroseleratic Heart Disease Immediate Ceuse (Finel disease or condition resulting In death) /Medical Examiner Examiner Cardio megaly
Due to (or as a consequence of): and I-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest physician a Box 68760, monary Physician/Medical 88 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? P.O. ed by the detached 1 Yee 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has birector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 28. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3□ DOA funeral 27. Menger of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Dev Year) 28c. Injury et Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident ofter death 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 2 filled 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. 29a. Certifier edical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signeture and Ittle of cartifie 29c. License number 29d. Dale signed (Month, Day, Year) e of death (Item 23e) (Type, Print)
WALAM) 14 30. Name and address of person who completed call 14211 Lawrel pron Dr Laurel MD 2070) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

JUL



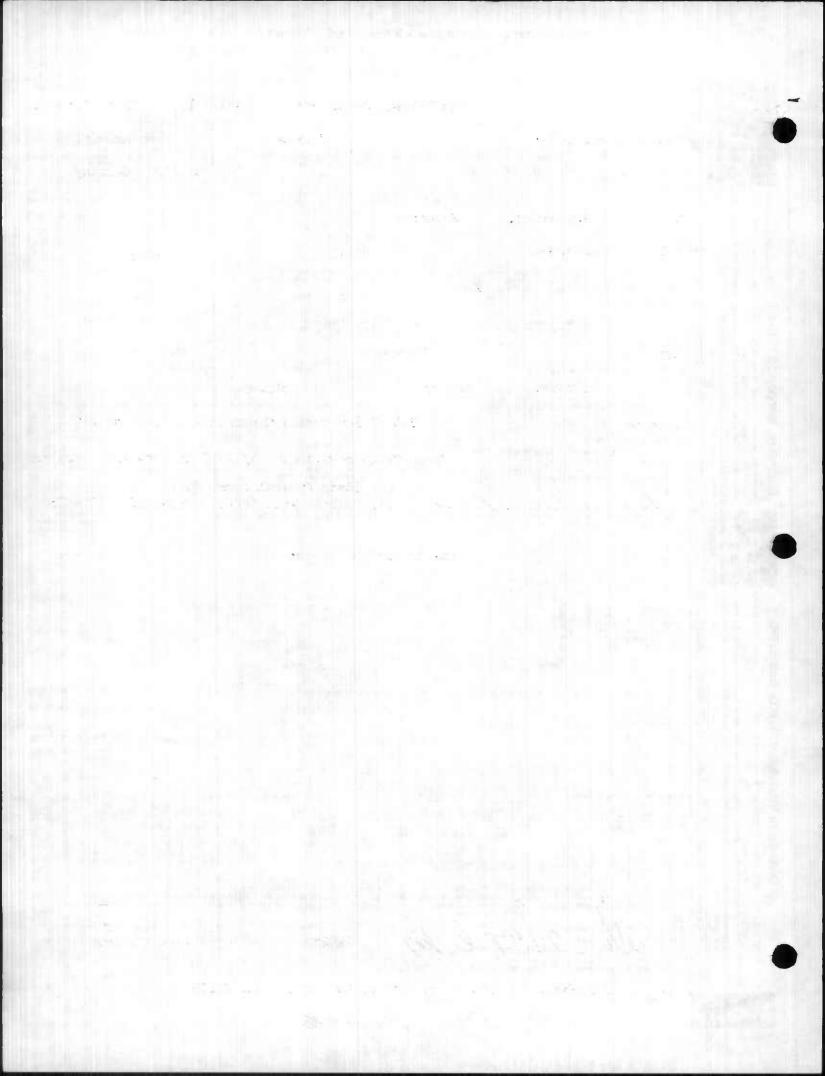
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** July 1999 Edith Hildegarde Weaver 10, 10:36 am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 228 Beechwood Drive Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Aug 30, 1933 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** Deys Hours 1□M 2XF 65 Yrs Germany **Director** 214-82-6549 Usual Residence of Decedent with the Maryland r 28a-f show 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ¥ Yes 2 □ No MD Anne Arundel Pasadena Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe permit. Pages 1 end 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or i en yinjury or other traumatic avent, the Modical Examiner must be in once. 228 Beechwood Drive 22112 Germany Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: SpecifiWhite þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) Coilege (1-4or 5+) Grade 10 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) unknown Reiner unknown 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 700 Willow Trail, Crownsville, Maryland 21032 John Weaver /son 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriei 2 X Cremetion 3 ☐ Removel from Stete 7/12/99 Catonsville, Maryland Metro Crematory, Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lignal 22. Name and Address of Facility Donaldson Funeral Home, P.A. 231 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest,

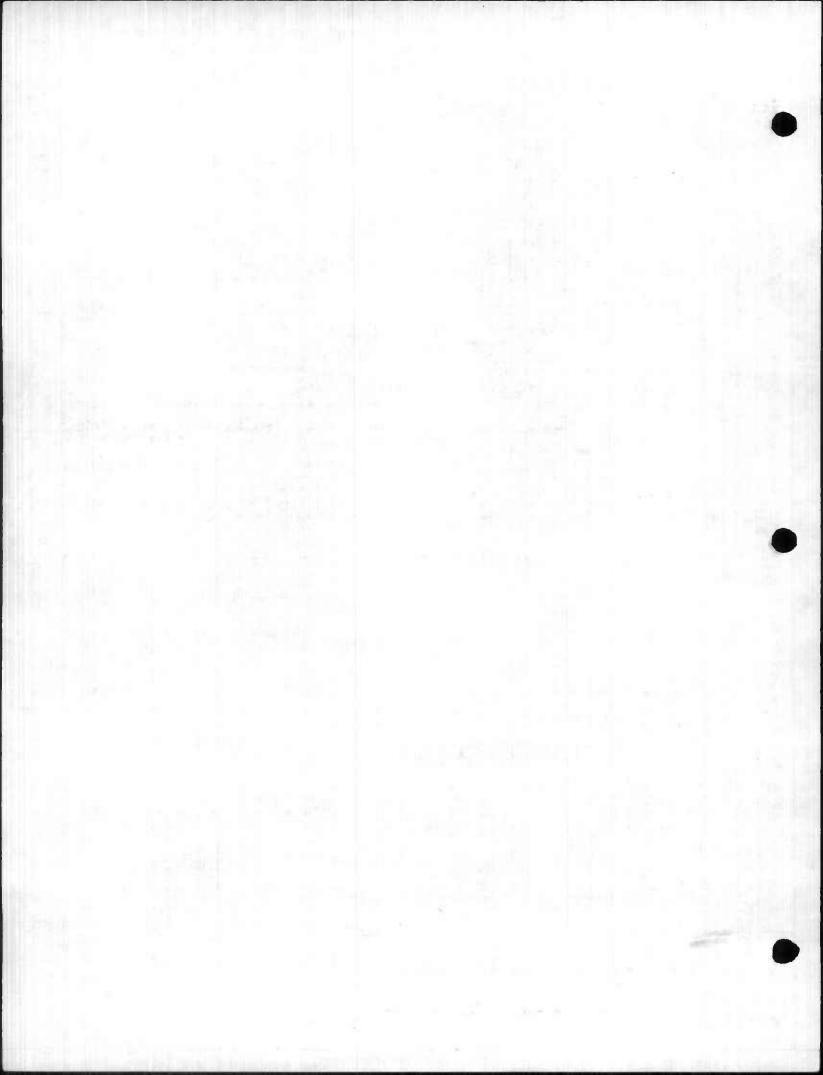
Approximate Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) Metastic bladder cancer 3 years **Examiner** Due to (or es a consequence of) Examiner certificate be executed physician and the burief-transit Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 80 957 0 signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 ₩ Unknown Division of Vital Records, py 24b. Were autopsy findings available prior to 24e. Was an autopsy Completed peen completion of cause of death? page 2 hes 1□ Yes 2□No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, 25. Was case referred to medical axaminer? Be 28. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2□ No 2 1 inpatient 2 ER/Outpatient 3 DOA sing funeral 27. Manner of Death 28d. Describe how injury occurred 28e. Dete of injury (Month, Day Year) 28b Time of 28c. Injury et Work? After Certification: 5 Pending investigation 1 Neturel 1 Yes 2 □ No daeth. 2 Accident after daeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) end manner as stated.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completaly fi Medical (Check only one) 29c. License number 29b. Signature 29d. Date signed (Month, Dey, Year) D24356 July 12, 1999 30. Neme and eddress of person who completed oduse of death (Item 23a) (Type, Print) Waterfield MD 900 Caton Avenue, Baltimore, Md. 21229 32. Registrar's Signature State JUL

Registrar



1. Decedent's Name (First, Middla, L		Certificate o	r Death	R	eg. No.	
Loretta			Yuman	2. Date of Dear	Day	Year 3. Time of Death
4a Facility Name (If not Institution, g	Barbara pive street and number)	-		July or Location of Death	25, 19 4c. County	
Salisbury Center	r: Genesis Elder	Care	Salisbu	rv. MD	Wicom	nico
	Sex / 7. Aga (In yrs. la	1 22	ar If Under 24 H	rs. 8. Date of Birth		Birthplace (Stata or Foreig Country)
214-30-8816	10 M 200 F 64	Yrs. Months Day	rs Hours M	Dec, 2		Maryland
Usual Residence of Decedent 10a. Stata 10b. County	100 City	Town or Location			,	
,		,				10d. Inside City Limits 1
MD DORC	hester C	ambridge 101. Zipcode			0- 0%	
0 -	.0 1		613		Og. Citizen of V	
805 Baylu	12. Was Decedent Ever in U,S			/Specify Ves or No.	000	e - American Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forcas?	. 13. Was Decedent of If Yes, specify Control of It Yes 2 M N		erto Rican, etc.)		ck, White, etc.
15. Decedent's I	Education	16a. Decedent's Usual Occ	cupation		16b. Kind of Bu	usiness/Industry
(Specify only highest g Elamentary/Secondary (0-12)	rada completed) College (1-4or 5+)	(Give kind of work dor life. DO NOT use reti	ne during most of v ired)	vorking		
2	College (1-401 5+)	PRoduc	tion		Seafo	od Industry
17. Father's Neme (First, Middle, Las				lama (First, Middle, I		
Lawrence	Henry S	tanley	Hest	er Est	telle 1	Moaney
19a. tnforment's Name/Relationship	(Type, Print)	19b. Meiling Address (Stre	et and Number or	Rural Route Number	City or Town,	State, Zip Code)
	iee	816 Robbins	5 Street	- Cambric	Ige Mi	D, 2/6/3
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	COL	ce of Disposition (Name of metery, crematory or other p	viace)			City or Town, State
4 Donation 5 Other (Spec		dtown Ceme	tery	17/31/99 (ambr:	dge, Maryland
21. Signature of Funeral Service Lice	ensee	22. Nama and Add	trass of Facility	1 Home	P.A.	1)
Janelle C,	Henry	5 INVIOSI	himoton's	St Camb	12:200	MD. 21613
		7,000)egstern	Enler		mund
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	Due to (or e	as a consequence of): as a consequence of):	eptim	ypring		Cranoll
rasulting in death) Last	Due to (or a	as a consequence of): as a consequence of): as a consequence of):				ntribute to the cause of deeth
that initiated events	Due to (or a	as a consequence of): as a consequence of): as a consequence of):			obacco use co	ntribute to the cause of deeth
that initiated events rasulting in death) Last	Due to (or a	as a consequence of): as a consequence of): as a consequence of):		23b. Dld to	obacco use co	
that influted events rasulting in death) Last	Due to (or a	as a consequence of): as a consequence of): as a consequence of):		23b. Dld to	obacco use cor es 2 No in autopsy	
rasulting in death) Last	Due to (or a	as a consequence of): as a consequence of): as a consequence of):		23b. Did to	obacco use cor es 2 No in autopsy med?	3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause
Pert II. Other algnificant conditions PORS/STANT Uygo Slyces 25. Was case referred to medical	Due to (or a	as a consequence of): as a consequence of): as a consequence of):	given in Part I.	23b. Did to 1 U Y	obacco use couse couse 2 Moon autopsy med?	3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause of death?
Pert II. Other algoriticant conditions PORSISSENT USB Slyces	Due to (or a Due t	as a consequence of): as a consequence of): ing In the underlying cause	given in Part I. Z TD 26. Place of E	23b. Did to 1	obacco use couse 2 No in autopsy med?	3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yas 2 No
Pert II. Other algorificant conditions PORS/STEAT Was case referred to medical axaminer?	Due to (or a Due t	as a consequence of): as a consequence of):	given in Part I. 26. Place of Dither: APRINGS 1 270 28. Place of Dither: APRINGS 1 29. No.	23b. Did to 1	obacco use cores 2 No en autopsy med? as 2 No ence 6 Othow injury occur	3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yas 2 No
Pert II. Other algnificant conditions POPS/SSENT USBO SLUCE 25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 2 Neutral 5 Pending investigating investigating algorithms and performed investigating investigating and performed investigating and performe	Due to (or a Due t	as a consequence of): as a consequence of):	26. Place of Dither: De Nursing jury at lork?	23b. Did to 1	obacco use codes 2 Mo in autopsy med? as 2 No in autopsy med? ance 6 Othow injury occurs injury oc	3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause of death? 1 Yas 2 No er (Specify) red per or Rural Route Number,
Cause (Disease or injury that initiated events rasulting in death) Last Pert II. Other algnificant conditions PORSISTEM 25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation of the could not determine of the could not determine (Check only one) 29a. Certifier (Check only one) Medical Examiner)	Due to (or a d. Due to (or a d	as a consequence of): as a consequence of):	26. Place of Dither: (Nursing jury at lork? Yes 2 No	23b. Did to 1 Ye 24a. Was a perion 1 Ye 28d. Describe he 28d. Describe he 28d. Location (Single or Town loce, and due to the cocurred at the time, described in the cocurred at the cocurred	bacco use cores 2 No in autopsy med? Bes 2 No in autopsy med?	3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause of death? 1 Yas 2 No er (Specity) red per or Rural Route Number, anner as stated, and due to the cause(s)
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Pert II. Other algnificant conditions PORS/SSENT LUGO SLUCE 25. Was case referred to medicel axaminer? 1 Yes 2 No. 27. Manner of Death 1 Onstural 5 Pending investigating and suicide 6 Could not determined 6 Could not determined 29a. Certifier (Check only one) 2 Medical Examined 29b. Signature and tally of certifier 29b. Signatur	Due to (or a Due t	as a consequence of): as a consequence of):	26. Place of Dither: (Nursing jury at lork? Yes 2 No	23b. Did to 1 Ye 24a. Was a perion 1 Ye 28d. Describe he 28d. Describe he 28d. Location (Single or Town loce, and due to the cocurred at the time, described in the cocurred at the cocurred	bacco use cores 2 No in autopsy med? Bes 2 No in autopsy med?	3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause of death? 1 Yas 2 No er (Specity) red per or Rural Route Number, anner as stated, and due to the cause(s)
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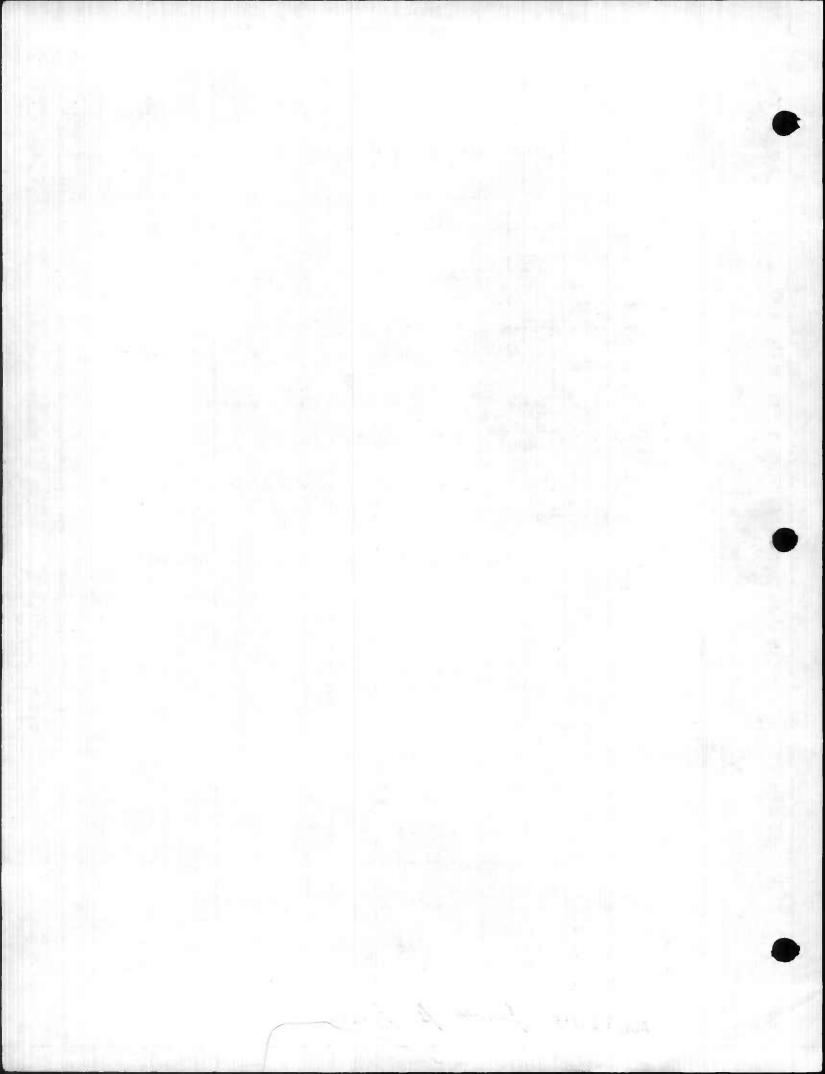
WRC 99-4346-510 JOHN AD

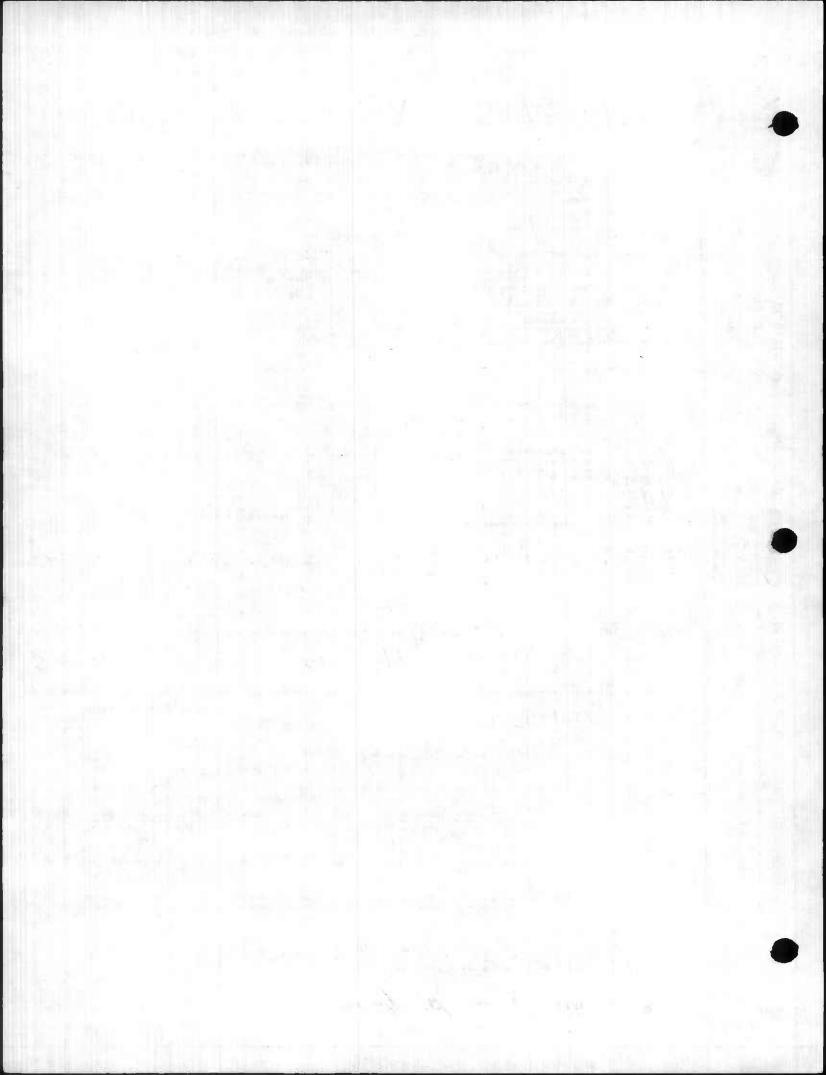
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State of Maryland / Department of Health and Mental Hygiene QQ 25296

allu /	Department of Fleathrand	IAI
	Cartificate of Death	

KINS			C	ertificate	of Deat	h		Reg. No.	2	20200
	1. Decedent's Neme (First, Middle, La	st)					2. Dete of De			3. Time of Death
Physician	John D. Adkins						JULY	23, Dey 199	9 Year	6:25 PM.
/Medical Examiner	4a Facility Neme (If not institution, giv 126 S. WOLF ST.					Town, or Lo	ocation of Dear	th 4c. Coun	ty of Deeth	
Funeral Director	5. Social Security Number 6. S 242–28–9979	22	n yrs. last birthda 80 Yrs.	Months D	Year If Und Days Hour		8. Date of Bi (Month, D.) May 5,	rth ay, Year)	9. Births Cour VA	olece (Stete or Foreign ntry)
	Usual Residence of Decedent						riay J,	1717	VA	
with the Maryland a or 28a-f show the notified at	10a. Stete 10b. County		Oc. City, Town or Baltimor						1	10d. Inside City Limits 1 Yes 2 No
vith the Mar or 28a-1 s be notified Director	10e. Street and Number		Daitimoi	10f. Zip Co	ode			10g. Citizen of	What Cour	ntry?
th with	126 S. Wolfe St	reet		21	.231			II	.S.A.	
de Fil de	11. Marital Status	12. Was Decedent Eve Armed Forces 1111	r in U.S. 13	Was Deceden	t of Hispanic (Origin? (Sp	ecify Yes or No	o- 14. Ra	ce - Americ	
by by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	KIIOWII	1 ☐ Yes 2 €			rican, etc.)		eck, White, i/y: White	
27 and and and and and and and and and and	15. Decedent's Ed (Specify only highest gra		(Gi	edent's Usual C	lone during m	ost of work	ina	16b. Kind of I	Business/In	dustry
within ene.	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use	retired)					
Hiled w Hygier The th		ınknown	Lab	orer	1 22 22			Luml		
d 2 should be filed th and Mentel Hygi 7 is marked other traumatic avent,	17. Father's Name (First, Middle, Last,						e (First, Middle	a, Maiden Suma	ime)	
should be and Mentel marked or marked or To Be	Joe Pete Adkins				_	nown				
2 4 4 5	19e. Informent's Neme/Relationship (unknown		unkr	own		nber or Huri		ber, City or Town		
pemit. Peges 1 end Department of Heelit Important: If Item 27 any Injury or other t once.	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Specif	Removal from State	20b. Place of Dis cemetery, cr	position (Name remetory or othe	of ir place)		Dete	20c. Location	- City or To	own, Stata
permit. Peges 1 e Department of He Important: if item any injury or othe pnce.	21. Signature of Funerel Service Licer Ronald S.	Wade, Dire	ctor	22. Name and A State Ar Saltimor	atomy	Board	-	W. Balt:	imore	Street
Physician /Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finel disease or condition	Attros	sclast					Sease	3	Approximate Interval Between Onset and Deeth
	resulting in death)	Du	e to (or as a cons							
licate be executed physician and s the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Du	e to (or as a cons	equence of):						
2 0 a	that initiated events resulting in death) Last	d.	e to (or as a conse	equence of):						
death certified at least a steel at least a second at least a seco									1	
by the by the lacked	Pert II. Other significant conditions of	ontributing to death but n	ot resulting in the	underlying caus	se given in Pe	ort I.		Yes 2 No		o the cause of death? bably 42 Unknow
been sign should be								s an autopsy omed?	av	fere autopsy findings vallable prior to ompletion of cause death?
certificate has rector, page 2							190	Yes 2□No		☐ Yes 2☐ No
ificat or, p	25. Was case referred to medical	-			26 Ple	ace of Deat	h (Check only			
Physician: The Ithis certificate harral director, page	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpati	ent 3 DOA	Other			idence 6 🗆 O	ther (Speci	fv1
ng Ph ther th uneral	27. Manner of Death 112 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Y			Injury et Work?			how injury occi		
क से ते हैं	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, : Specify)	street, factory, o	ffice			(Street and Nun own, State)	nber or Run	al Route Number,
Ne Hospital n 24 hours Ne Funeral pletely lilled edical C		ysician: To the best of miner: On the basis of exand manner stated	amination and/or							
within 2 To the comple	29b. Signeture end title of outsides			29c. L	icense numbe	9r		29d. Date sign	ned (Month,	Day, Year)
	1/mg	Xya,	, It		O.C.M.E	Ξ.		JULY 2	4, 199	99
Qr .	30. Name and address of person who	completed cause of deat	h (Item 23a) (Typ 111 Peni		, Balt	imore	e, Mary	land 21	201	
State	31. Dete filed (Month, Day, Year)	32. Registrar's	Signature	1	,					





State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Robert Oscar Biern 1999 8:30 am /Medical August 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 204 Shiley Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 180 M 2□ F Months Yrs 66 Dec. 21, Director 234-54-7097 1932 Va. Usual Residence of Decedent the Manyland or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiena. Important: if Itam 27 is merked other than "natural", or hame 23a or 2 and Injury or other traumatic avant, the Medical Examiner must be an and. 204 Shiley Road 21401 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Ki Yes 2 □ No If Yes, Give Year or Dates: 1962-64 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. 11. Merital Status 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Physician Medical 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) B Oscar Bernard Biern Charlotte Egri 19a. Informant's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Biern/spouse 204 Shiley Road, Annapolis, MD 21401 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama end Addrass of Facility tonald S. Director Wade State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 Part I. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, took, or heart feilura. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician LYMPHORNA Immediata Cause (Final disease or condition resulting In death) 39 mos /Medical Examiner Due to (or as a consequence of) Examine attending physician and for use as the burial-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760. edical that initieted events resulting in death) Lest Due to (or es a consequence of) Physician/M P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. À 2 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed cartificata has 1 Yes 2No 1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only ona) 1 Yas ZENO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 funarai spital or Attanding Phoours after death.

Seral Director: After the filled in by the funaral. 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Cartifier end manner stated. 29b. Signature and title of certifier 29d. Dale signed (Month, Day, Year) 29c. License number um 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) 900 BESTEATE PD 300 STANLE

DHMH 16 Rev 6/95

State Registrar

AUG 1.1 Mga

99-4313-510

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

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7		-	2	4	0
	Some	0	S-m	1	0

3. Time of Death

7:53P.M.

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2 No

RNES AMEN	D ITEMS: #2					0 10 .	7061	uncai	6 0	Dea	<i>U1</i>	0.0	Reg. I	No.		1
Physician	1. Decedent's Nar											2. Date of Month		Day 10	Year	3. Time
/Medical	Car		Barn							A1 016	Town and	JULY		2,19	311 725	7:53
Examiner	4a Facility Name 1722 N.	BETHEL S	-		umoer)				П	,	LTIMO		eath 4	4c. Count	y of Deat	1
Funeral Director	5. Social Security unknown	Number	6. Sex	M 2□ F	7. Age	(In yrs. last i	oirthday) Yrs.	If Unde Months			der 24 Hrs. rs Min.	8. Date of (Month,	Birth Dey, Yes	946	9. Birti Co unki	nplace (Stetuntry)
	Usual Residence	Y														
b or 28a-1 show be notified at Director	MD	10b. County				Balti										10d. Inside
ral Director	10e. Street and N	umber N. Bethe	1 S	treet				10f. Zig	Code 212					Citizen of	What Co	untry?
by Funeral		unknown		2. Was Dec Armed F 1 Yes If Yes, G Year or I	orces?u1 2 ☐ No live	nknowr		Was Dece Yes, spe	2 N			pecify Yes or o Rican, etc.)	No-		ick, White	
peted		15. Decedent	s Educa	ation	STAR STAR	18	n. Deced	lent's Usu	el Occ	upation e during	nost of wor	tking	16b.	Kind of E		
Completed	Elementery/Sec unknown	condary (0-12)	unl	College ((1-4or 5+)		knov		se reti	red)			uı	nknov	wn	
Be	17. Fether's Name	(First, Middle, I	ast)			1				18. M	other's Ner	ne (First, Mid	ldle, Maide	en Sume	me)	
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Injury or other		sposition Cremetion 5) Other (Sp				20b. Place				lece)	1	Date	20c.	Location	- City or	Fown, State
8008 5008	21. Signiture of F	Ronald	5/	Wade,	rele	ector	St	altim	Ana	tomy, MD	Boar 212			Balt:	imore	St.
cian ! lical	Immediate Cause	(Final	complications on the complex of the	cause on	each line.	ROTIC (or respirator	ry errest,			Approxim Interval E Onset an
ner	disease or conditi resulting in deeth	on)	8.7			ue to (or es						-			1	
Examiner	Sequentially list c	onditions,	Ь.		Dı	ue to (or as	conseq	uence of):								
SAI EX	Sequentially list of any, leading to i cause. Enter Und Cause (Disease of that initiated even	mmediatė lertying r Injury	c												į	
se as the burial-transit VMedical Examir	resulting in death)		d		Du	e to (or as	conseq	uence of):							1	
Physician/M	Part II. Other sign	ificant condition	ne contr	ibuting to o	death but i	not resulting	in the ur	nderlying o	ause	given in P	art I.	23b. I	Old tobac	co uee c	ontribute	to the caus
be detached for use at by Physician/Me												1	□ Yee	32 No	3 □ Pi	obably 4
should should													Vas en au erformed?			Were autops available price completion of of death?
												1	Yes	2□No		Yes 2
Sirector Sirector	25. Was case refe examiner?		Ho	spital:						ther-		ath (Check or				
funeral fon:	1)X) Yes 2			28a. Date		2 ER/0 (ear) 28b	Time of Injury		28c. In	41		28d. Descri				cify)
in by the	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could n	ot be	28e. Plac	e of Injury	/ - At home, (Specify)	larm, str					28f. Location	n (Street Town, Ste		ber or Ru	ral Route N

Physician/Mer Completed by Be Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certific

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

1. Yes 2 No

O-contractor					EO. I INCO OI DO	atti (Cirech Oriny Orio)	
examiner?	2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA	Other: 4 Nursing H	Iome 5 Residence	6 Other (Specify
27. Manner of 1 🕅 Natura		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	280	. Injury at Work?	28d. Describe how inju	ury occurred

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

**Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) O.C.M.E. JULY 23, 1999

30. Name and address of person who completed cause of death (Item 226) (Type, Print)

Radentz 111 Penn Street, Baltimore, Maryland 21201 Stephen S 31. Date filed (Month, Day, Year)

State Registrar

AUG 1 1 1999

within 24 hours after death. To the Funeral Director: A

- AUG 1 1 1958

WRC 99-4589-005 BARNETT A. FUGENE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieneg 9 25300

OLI VE					Cei	Tillicate o)I L	Jealii			Reg. No.			
Physician /Medical	1. Decedent's Nam		arnett							2. Dete of D Month AUGUS	Dey		ear	3. Time of Death 8:30 PM
Examiner	4e Facility Name (give street end nu				48	PARK		ocation of Dee		ounty of		
Funeral Director	5. Societ Security N 217-16-0	lumber 1820	6. Sex 1 XM 2 ☐ F	7. Age (In yrs.	last birthday) 75 Yrs.		ear ays	If Under 24		8. Date of B (Month, D	Sirth Day, Year)	9.		ice (Stete or Foreign y)
ryland the tal	Usuel Residence o	10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits
or 28a4 s be notified Director	MD 10e. Street and Nu	Balti mber	more	Ва	ltimor	e 10f. Zip Coo	de	-			10g. Citize	n of Wha	at Countr	1 ☐ Yes 2 🖺 No
at ba	2911 A	ndora C	ourt				21:	234			U	S.A		
72 hours after death with the Maryla natural; or items 23e or 28e-1 show steal Examiner must be notified at sted by Funeral Director	11. Maritel Status 1 Never Merr 3 Widowed		Armed F d 1 AYes if Yes, G	2 No 5/	42-	Was Decedent f Yes, specify (1 ☐ Yes 2 🔯			n? (Spi Puerto	ecify Yes or N Rican, etc.)		Black,	America White, et	tc.
fural at Ex	3 🗆 Widowed	15. Decedent's	Year or I	Dates: 11	/62	dent's Usuel Oc	YUD9	tion			16b. Kind			
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Mental Hyg nked other fic event, To Be C	17. Father's Neme									e (First, Middl McClu1		meme)		
DU S	19a. Informant's No	eme/Retetionshi	ip (Type, Print)		19b. Mailie	ng Address (St	reet a	nd Number	or Run	al Route Num	ber, City or T	own, Sta	ate, Zip C	Code)
127	Gary Lutt		ecutor			Sherbo		ne Dr.	,]		_		093	
ant: if Nac ury or oth			3 □Removel from ecify)	1 0	flece of Dispo emetery, crea	sition (Name o netory or other	f plece	9)	1	Dete	20c. Loca	tion - Cit	y or Tow	m, State
Depart Import any in phos	21. Signature of Fu		9 Wate	Direct	or S	Neme and Actate Ar	at	omy Bo	oaro		W. Ba	ltim	ore	Street
ending physicien and ruse as the burial-transit an/Medical Examiner	Immediate Cause disease or condition resulting in death) Sequentially list condition in the cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, nmediate orlying Injury	a. Cor	Due to (o	or as a consecutive as	uence of):	on	-dy	No	ch_				
ned by the etter deteched for u	Part II. Other signif	icant condition	s contributing to d	leath but not resi	ulting in the u	nderlying cause	give	n in Part t.			d tobacco us		bute to	the cause of death'
has been signing 2 should be mpleted b										lin	is an autopsy formed?		com of de	a autopsy findings lable prior to apletion of cause eath?
E o o	25. Was case refer	red to medical					_	26 Place o	/ Doot	h (Check only	Yes 2	No	1/2	Yes 2□ No
	examiner?	No	Hospitel:	Inpatient 2	ER/Outpatier	t 3D DOA	Othe	Mar.		me XXRes		Other ((Specify))
2.7	27. Menner of Deet 1 Natural 2 Accident	5 Pending investige	28a. Dete		28b. Time of Injury	28c.				28d. Describe			rely	/
rs after death. al Director: After t led in by the funers Certification:	3 Suicide 4 ☐ Homicide	6 Could no determin	ed 289. Place	e of Injury - At ho ing, etc. (Specif		eet, lactory, off	ice)		281. Location City or To	(Street and I own, State)	29	or Moral	House Number,
within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff	29a. Certifier (Check only one)		Physician: To the caminer: On the b and man											
To the comple	29b. Signeture and 30. Name end address	entre	11.6	1 mg	220) (T			number C.M.E.			29d. Date :			
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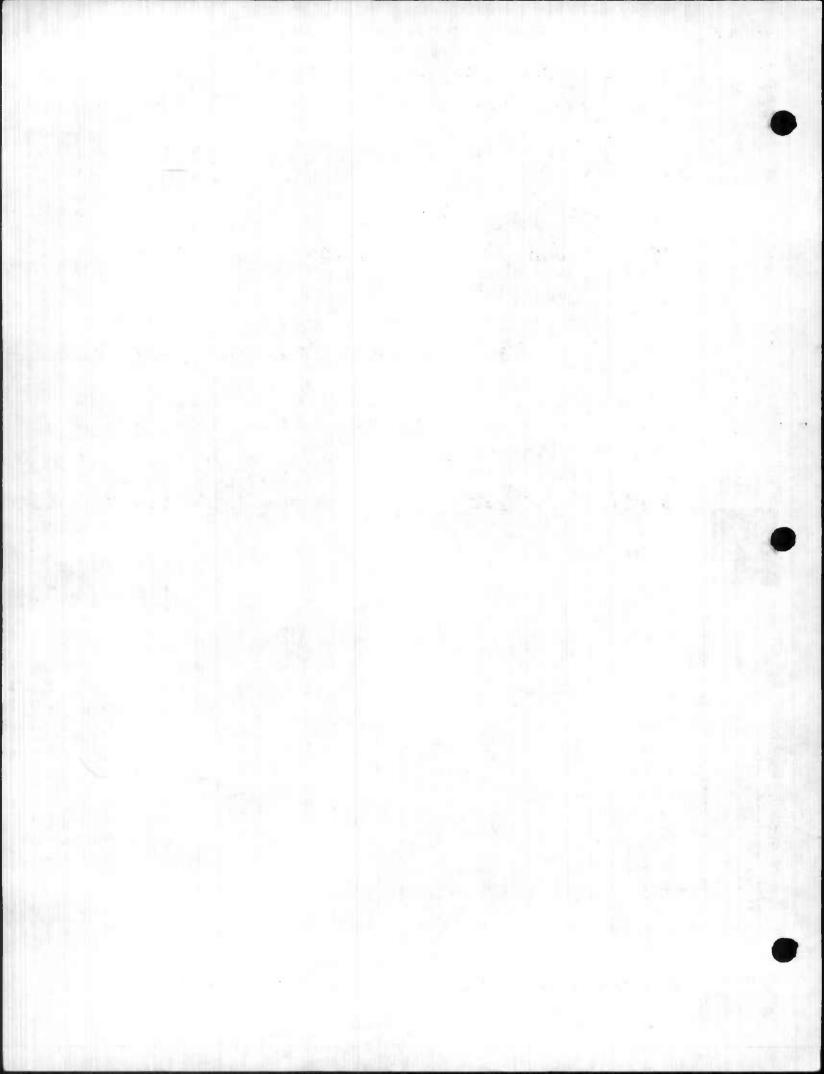
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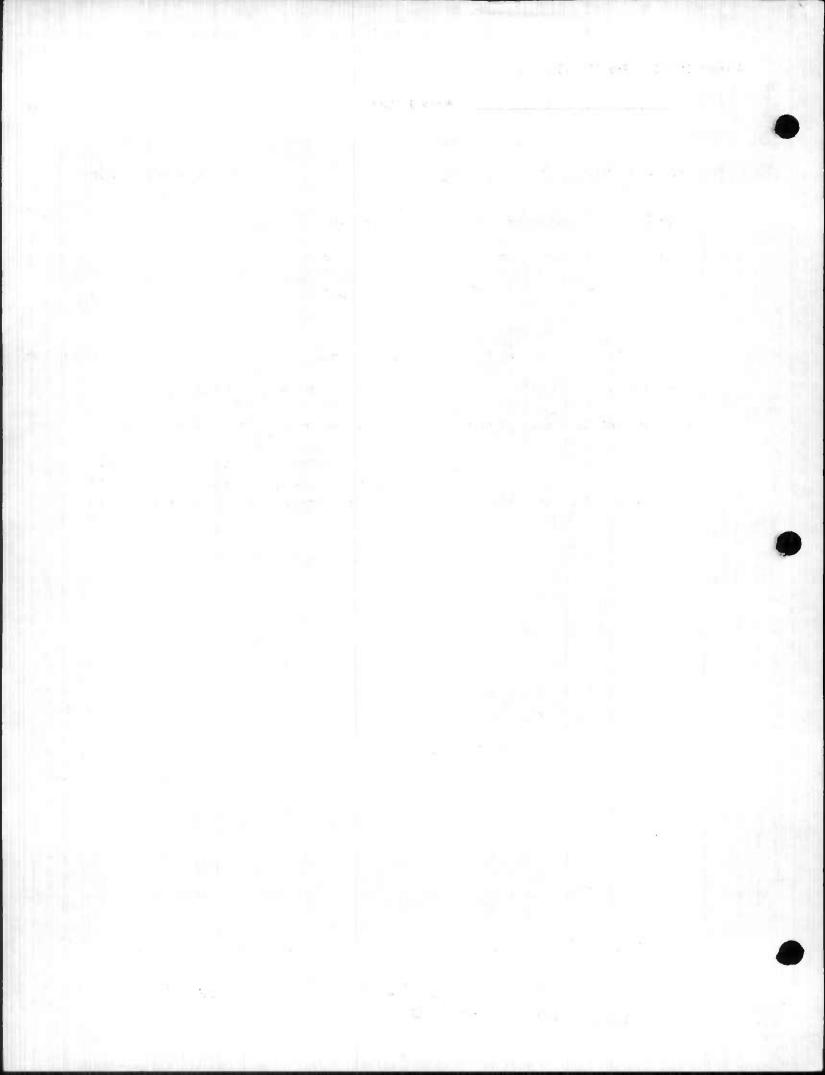
WRC				
99-4616-510				
(RONALD BLA	Amend ITEMS: 23PA Righter Maryland Department of Health CKLEDGE) AMEND#8 PER F.H. G774 8-12-99 J.A. Certificate of Dealth	h and Mental Hygiene of the Reg. No.	19 25303	
	1. Decedent'a Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death	
Physician /Medical	Ronald Blackledge		1999 6:46 PM.	
Examiner	4a Facility Nama (If not Institution, give street and number) 4b. City,	, Town, or Location of Death 4c. Co	ounty of Death	
22		ALTIMORE Ider 24 Hrs. 8 Date of Birth . 7-15	13	
Funeral Director	5. Social Security Number 2/6-4/0-03/6 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) Yrs. 1 Under 1 Year If Under 1		-43 9. Birthplace (State or Foreign Country)	
ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Meryland it has the and Mental Hygiene. If health and Mental Hygiene. other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location		10d. fnside City Limits 1	
	10e. Street and Number 10f. Zip Code	10g. Citize	n of What Country?	
	914 N. Linwood AVE. 21205	U,	5. A.	
	11. Marital Status 12. Was Decedent Evar in U.S. 13. Was Decedent of Hispanic from Forces? 13. Was Decedent of Hispanic ff Yes, specify Cuban, Mexit	Origin? (Specify Yes or No-	Race - American Indian, Black, White, etc.	
	1 Never Married 2 Married 1 Yes 2 No Specify:		Specify: RINCK	
	325Widowed 4 Li Divorced Year or Dates:		DIACK	
	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during n Iffe. DO NOT use retired)	nost of working	of Business/Industry	
	Elementary/Secondary (0-12) College (1-4or 5+) C Rown Col	rK-Steel CI	AN Co.	
	17. Father's Name (First, Middle, Last)	other's Name (First, Middle, Maiden Su	imame)	
	William BlackLedge Mary Bennett			
		umber or Rural Route Number, City or T	7 11 1 -	
			SAlto., Mcl. 21205	
0 2 - 7	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State			
Baltim permit. Pag Department Important: any Injury once.	4 Donation 5 Other (Specify) NI. Zibn Cemetery 18/12/99 Baltimore, MARYland			
Ball Ball	21. Signature of Funeral Service Licensee 22. Name and Address of Facility ITS Funeral Home			
	Glacian Sette 1129 N. CAroline St. BAltimore MARYLAND 2121			
	Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death			
Physician /Medical	Immediate Cause (Final disease of condition DILATED CARDIOMYOPATHY			
Examiner	resulting in death)			
9	Due to (or as a consequence of):			
outed transit	Sequentially list conditions, Due to (or as a consequence of):			
O 5 5 0	if any, leading to immediate			
rifficate be ng physicis as the bu	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Me se se				
, P.O. Box 68760, that the death certificate be so of by the attending physician detached for use as the buriar / Physician/Medical E.	0.			
	Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	art I. 23b. Did tobacco us	a contribute to the cause of death?	
		1 Yes 2	No 3 Probably 4 ₩iknown	
O 2 55 D		24a. Was an autopsy	24b. Were autopsy findings	
of Vital Records, Physician: The law requires the this certificate has been signed and director, page 2 should be earliered by the Completed by		performed?	available prior to completion of cause	
		10/es 20	of death?	
	25. Was case referred to medical 26 P		No No No No No No No No No No No No No N	
	examiner? Hospital: Other:	Place of Death (Check only one) ☐ Nursing Home 5☐ Residence 6%	Wither (Specify) AT	
Physical districts of T. T. T.	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how injury of	792778777	
ion ading ath.	1 ဩNatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident invastigation M 1 ☐ Yea 2	≥□No		
Division or Attending alter death. Director: Alter times in by the tune ertification	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)	28f. Location (Street and I City or Town, State)	Number or Rural Route Number,	
Division of that or Attending P in after death. The Divector: After led in by the funent Certification:	building, etc. (appeary)	Only or Youn, Oralloy		
cal ty me	29a. Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion,	and place, and due to the cause(s) ar	nd manner as stated.	
	one) and manner stated.			
Total Service		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. AUGUST 09, 1999		
	Millime befoll on control			
Pin	Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201			
M	1137437014 12 120 100 0C	arthiore, maryland	1 21201	
State Registrar				
DHMH 16 Ray 6/95	AUG 12 1999 Server B. Sports			

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

Amended Item#1 perPhyG774 8/16/99 EW Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaa **Physician** 9:45 AM Henry J. Borig HENRY, R. BORIG 11, 1999 AUGUST /Medical 4a. Facility Nama (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner NURSING HOME BALTIMORE EVERGREEN If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number If Under 1 Year 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 100M 2 F Months Days Yrs. Director 215-05-7915 October 2, 1918 MD Usual Rasidanca of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at TARKVILLE 1 Yes 2 TNo Director MD BALTIMORE 10e. Street end Numbar 10f. Zip Coda 10g. Citizan of What Country? 5 WILSON 21234 or items 23e 8113 AUE U.S. A Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ Ho If Yas, Giva Yeer or Datas: Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, atc. 11. Maritel Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: WHITE Specify: by 3 Widowad 4 Divorced "natural", Completed 15. Dacedant's Education (Spacify only highast grada completed) 16a. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantery/Secondary (0-12) Collega (1-4or 5+) 12+1 CROWN, CORK + SEAL, CON MACHENIST NIA 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Richard BORIG GREELEY MARY 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) (WIFE) Boris MILDRED 8113 WILSON AUE BALTS. am MRS 21734 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatery, cramatory or other place) 20c. Location - City or Town, Stata 1 Burlal 2 Clametion 3 Ramoval from Stata Greenmount cemetery 8/12/99 BALTO ND 4 ☐ Donation 5 ☐ Othar (Specify) HARTLEY MILLER FUNERAL HOME CHTD. 21. Signeture of Funaral Sarvice Licensee 22. Nama and Addrass of Facility 23a. Pert 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Milen RD BALTO, MD 2.234 Approximata Interval Batween Onsel and Death Physician Immediata Ceusa (Final disease or condition resulting in death) /Medical erebro Voscular acciant Examiner Due to (or es e consequança of): Physician/Medicai Examiner physician end s the buriel-transit Sequentielly list conditions, if any, leading to immadiata causa. Entar Underlying Ceuse (Diseasa or Injury that Initiated avents rasulting In daath) Last Dua to (or as a consequence of): Box 68760. Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the causa of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Dementin þ 24b. Wara autopsy findings eveileble prior to complation of cause of death? 24e. Wes an autopsy performed? Completed Arterioscioratic Cardio Vascular disease 2 100 1 TYas 1 Yes 2 No Division of Vital Be 25. Was casa referred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Darsing Homa 5 - Rasidanca 6 Othar (Specify) P 1 Yas 2 No 28a. Deta of Injury (Month, Day Year) funeral 27. Menner of Deeth 28b. Tima of Injury 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: ii or Attending F after deeth. I Director: After d in by the funer 1 Naturel 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarminad 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Hospital
 24 hours a
 Funeral D Medicai 29a. Cartifian t 🖰 Certifying Physician: To tha best of my knowledga, death occurred at the time, deta end placa, and dua to tha causa(s) and mannar as statad. (Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end piece, and dua to the causa(s) and manner stated. To the Within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signeture and titla of certifier D17992 30. Nema end addrass of person who complated causa of death (Item 23e) (Type, Print) Goricher BLUD, BALTO, MD KHIN 312 31. Data filed (Month, Day, Year) 32. Begistrar's Signature Registrar AUG 1 2 1999



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** August 8, 1999 9:03 P.M. Steve Burdusi /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Fairview Avenue Baltimore Baltimore If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months 1₩ 2□F Yrs. Director 216-36-0415 59 May 29,1940 Greece Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "natural", or itema 23a or 28a-1 ahow other traumatic event, the Medical Examinar must be notified at 1 Yas a No Director Md. Baltimore Baltimore-10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 Fairview Avenue U.S.A.

14. Race - American Indian,
Bleck, White, etc. 21224 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No If Yes, Give Army Year or Detes: Army Saltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: White à 3 ☐ Widowed 4 🗓 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e flied within 7 at Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Printer Newspaper 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health end Mentel th Important: if ham 27 is marked oth eny Injury or other traumatic even potes. Be Manuel Burdusi Rose Koumendouros 19e. Informent's Name/Ratationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Marcello Burdusi / Son 511 Fairview Ave. Balto MG. 21224

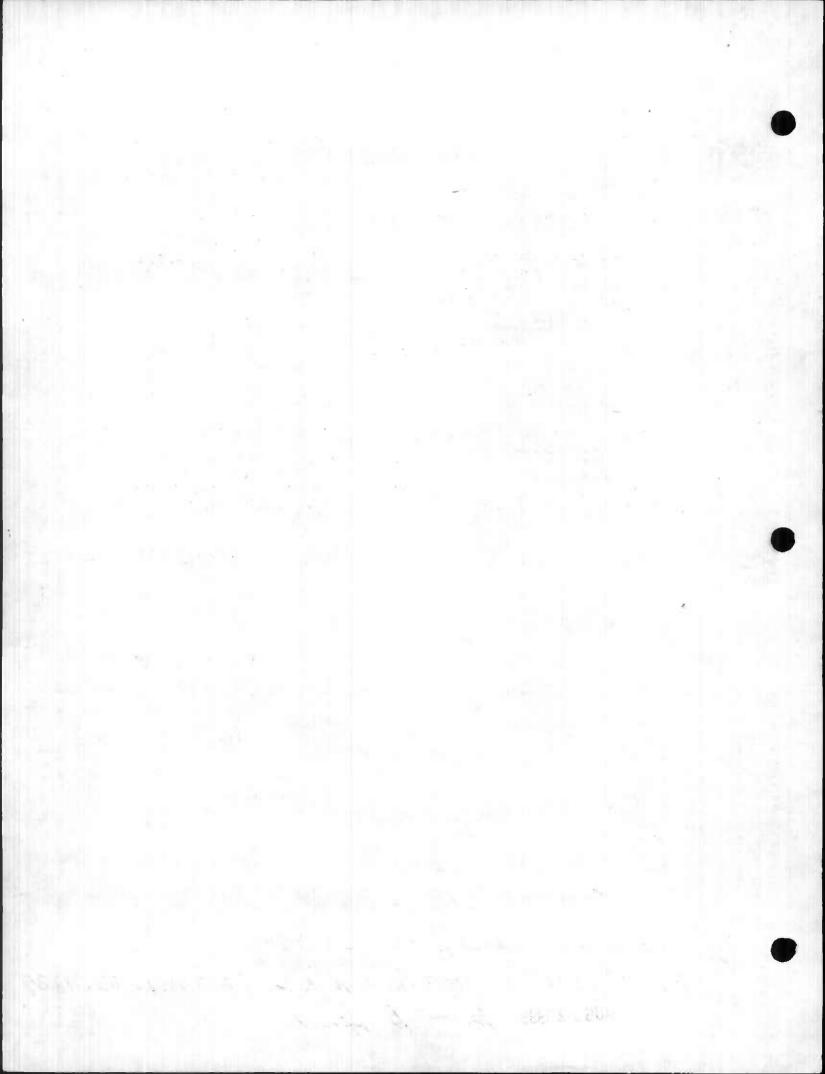
Mathod of Disposition (Name of Disp 20a. Method of Disposition cemetary, crematory or other piece) 1X Burial 2 Cremation 3 Removel from Stete Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8-12-99 Balto., Md. 21. Signeture of Funeral Service Lique 22. Name end Address of Fecility Bradley-Ashton-Matthews Funeral Home, Inc 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac of respiretory arrest, shock, or heart failura. List only one cause on each tine. 21222 Approximata Intervat Between Onset and Deeth **Physician** denocaranoma Immediete Cause (Finet /Medical disease or condition resulting in death) Examiner physician and the burial-fransit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Records, P.O. Box 68760. edical Due to (or es e consequence of): Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Wes case refarred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA To Other: 4 Nursing Homa 5 Hasidence 6 Other (Specify) 1 Yes 2 No funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Hospital or Attending PI n 24 hours after death.
 Funeral Director: After the pletely filled in by the funeral 28b. Time of 28c. Injury at Work? 1 Weturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of-certifier 30. Nama and eddress of person who completed causa of death (ttem 23e) (Type, Print) 9000 FRANKLIN DR. DR. BALTIMORE, MD 21237 1.), 9000 F 32. Registrer's Signeture

State Registrar

31. Date filed (Month, Day, Year)

AUG 12



State of Maryland / Department of Health and Mental Hygien (25306 Certificate of Death AMEND #3 PER MD. G774 8-12-99 J.A. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** RA CROCKET 2:35 A.M. /Medical 4c. County of Die 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner HOS Dice If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 20 F -20-Yrs. **Director** Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director M more 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 21215 Items 23a MA Funeral 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, Whita, etc. pemit. Pages 1 and 2 should be filed within 72 hours siter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or he any Injury or other traumatic event, the Medical Externes. 1 Nevar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva altimore, Maryland 21215-0020 1 Yes 2 14 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: BLAC Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) BAlto. COOK 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jwens KE ettie 2 John COC 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores SINIA roc KUT 10 DA HIMBIE 20b. Place of Disposition (Nama of 20a. Method of Disposition Date 20c. Location - City or Town, Stata cematary, cremetory or other place) 1 Suriel 2 □ Cramation 3 □ Ramoval from State Cemeter 10 4 ☐ Donation 5 ☐ Othar (Specify) 161 21: Signature of Funeral Service Licentee 22. Nama and Addrass of Facility Home nerpl 1129 N acoline 23a, Parti. Entar the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Causa (Final diseasa or condition rasulting In death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last attending physician for use as the buria P.O. Box 68760 Dua to (or as a consequence of USB as Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No ρ Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No 21110 certificate Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director; g 25. Was casa rafarred to medical examiner? Be 26. Plage of Death (Check only one) Other: 1 Yes 2 No Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be datamined within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida 29a Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. å 29d. Data signed (Month, Day, Year) 29b. Signature end title of centile 29c. License number use of death (Item 23a) d 31. Data filed (Month, Dey,

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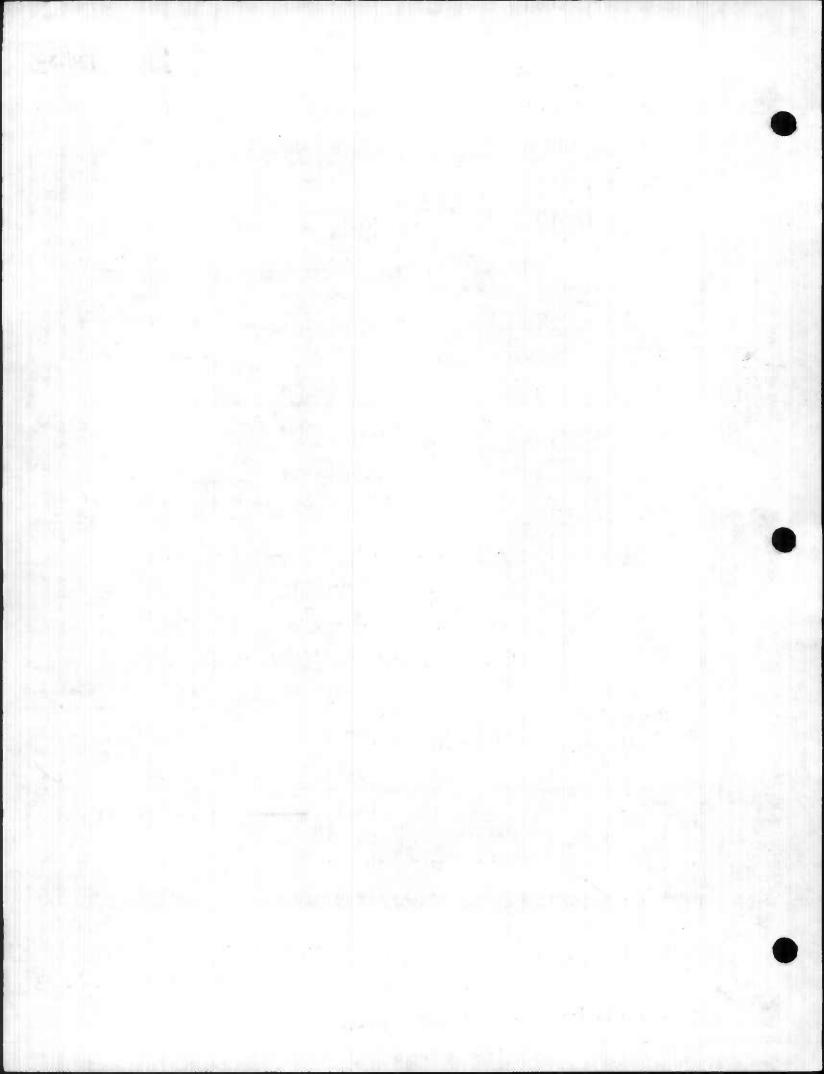
State

Registrar

AUG 12

1999

Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Dev **Physician** Month ANNA DELCHER 08 09 1999 6:40 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore St. Joseph Nursing Home If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Year, Nov. 25, 1909 If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplaca (Stete or Foreign **Funeral** Months Days Hours MD MD 212-40-4212 1 ☐ M 2 Ă F 89 Yrs Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Catonsville MD Baltimore 1 ☐ Yes 2 No Director 23s or 28s-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1222 Tugwell Drive 21228 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Stetus Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, Whita, etc. filed within 72 hours after Hygiene. ther than "natural", or its 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2 Married à Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Name (First Middle Last) Pages 1 and 2 should be fit ment of Health and Mental 19 ant; if them 27 is marked oth lory or other traumatic even å Saverio Scallio Maria Calderone 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morrell C. Delcher (Son) 105 N. Beaumont Avenue, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) New Cathedral 8/12/99 Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Interval Betwe Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner shysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): for use a P.O. Part fl. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 M Unknown by Records, 24b. Were eutopsy findings available prior to completion of cause of death? Cardiovasaula 24a. Was an autopsy performed? Be Completed page 2 After this certificate has 1 ☐ Yes 2 1 No 1 ☐ Yes 2 No Division of Vital or Attanding Physician: filled in by the funeral director, 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atlated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. completely (Check only 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier D08780 30. Nemi and state as of person who completed cause of death (Item 23a) (Type, Print) Frederick Rd. Ball may MD 21258 SIA 31. Date filed /M strar's Signature State Registrar

Total of many total alle

1. Decedent's Name (First, Middle, Lest)

Marvin Drumheiser

Box 68760,

P.O. Records, Division of Vital Hospital or Attending Pl 24 hours efter death.
 Funeral Director: After th

Marvin F. Drumheiser 10:30 AM August 10, 1999 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkridge 6754 Athol Ave If Under 1 Year If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) Min. (Month, Day, Year) March 27, 1907 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) MM 2DF 220-07-9047 92 Yrs. Pennsylvania Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 U.S.A 6754 Athol Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 W No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify White þ 3 □ Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Education Elementary/Secondary (0-12) College (1-4or 5+) Instructor permit. Pages 1 and 2 should be fitted a Department of Health and Mental Hygis Important: If item 27 is marked other 1 any injury or other traumatic event, III 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maider Sumame) Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6754 Athol Ave. Elkridge, Maryland 21075 Wife Mrs. Augusta Drumheiser 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 08/13/99 Brentwood, Maryland Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shick, or hour failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel a. CARDIAC ARRYTHMIA

Due to (or as a consequence of): 4 MONTHS disaase or condition resulting in death) **Examiner** Examiner YRS physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daeth) Last Physician/Medical Due to (or es e consequance of) as Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 40 HERPES ZOSTER 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings available prior to completion of cause of death? POSTHERDETIC NEURALGIA 24e. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatlent 3 DOA 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Investigation To the Hospital or Attendir within 24 hours effer death.

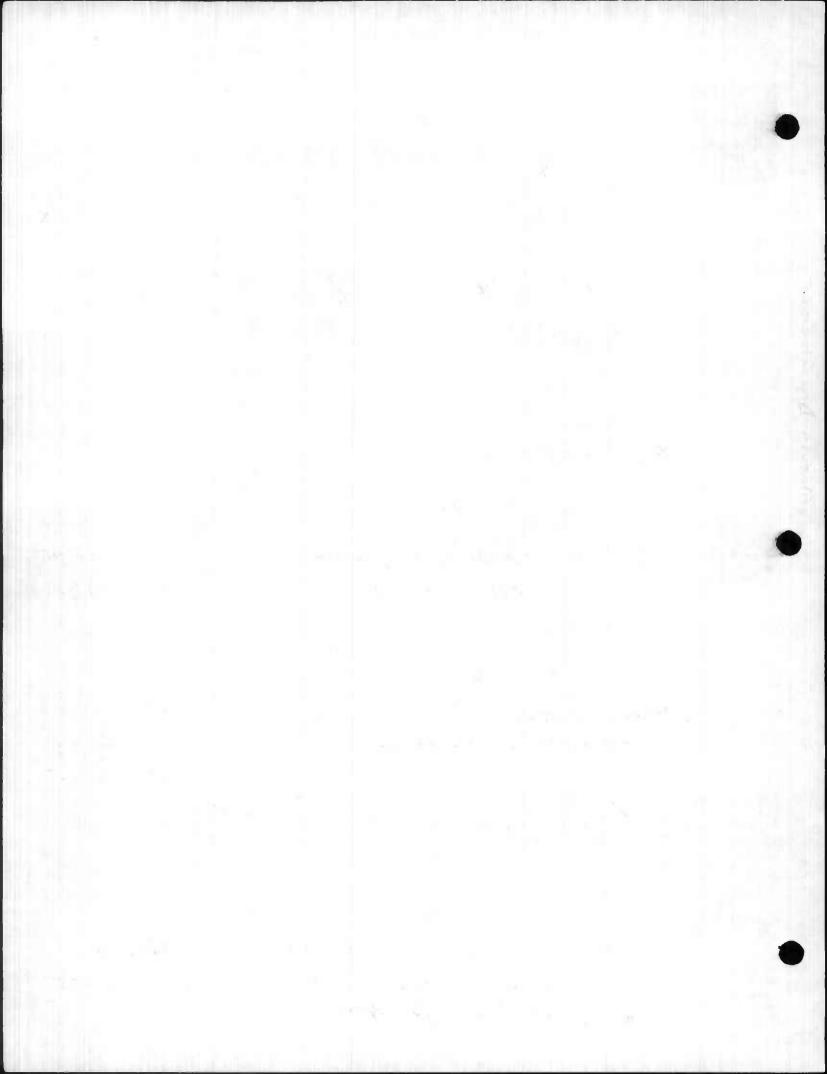
To the Funeral Director: All complately filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcida 6 Could not be determined Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifler 29c. Licanse number own lain, his D 22832 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Soon JA Kim 5808 MAIN ST. ELKRIDGE MD 21075 31. Dete filed (Month, Day, Year) 32. Registrer's Signature Registrar AUG 12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death

2. Dete of Death

3 Time of Death



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Time 1 th 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Auc arlan 1:25 9 1999 4b. City, Town, or Location of Death 4d. County of Death 4a. Facility Nama (If not institution, giva street and number) BALTIMERE
If Undar 24 Hrs. 8. Date of Birth SAMARATAN 6000 105P-5. Social Security Number if Under 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 6. Sex Days 1 M 2 F Months Hours Min. Yrs. MAR. 22 1928 216-20-4438 Usual Rasidance of Decedant 10h County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Md PARKVILLE BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8841 AUE WILSON 21234 450 12. Was Decedant Evar in U,S. Armed Forcas?

1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas: KORF4 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 Never Married 2 M Married 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) AEP BUTCHER 5 NA 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) DIETSCH GEORGE MARIE ZOCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) FE 8841 WILSON AV. BAI to Nd 21234

20b. Place of Disposition (Nama of cematary, cramatory or other place)

8 Pata 20c. Location - City or Town, Stata DIETECH / WISE MARGARET 20a. Mathod of Disposition 1ÆBurial 2 ☐ Cramation 3 ☐ Ramovai from Stata 12/99 GARSENS OF FAITH BALTO CO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funarai Sarvice Licensaa 22. Nama and Address of Facility/ER FUNERAL Home radios. 22 N 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Onsal and Death Immediata Causa (Final disaasa or condition resulting in daath) eumon Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Lest Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ N 1 Yas 2 NO 26. Placa of Daath (Check only ona)

Physician /Medical **Examiner**

Department o Important: If any Injury or

Physician

/Medical

Examiner

10a Stata

Funeral

Director

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n end Mental Hygiene. Is marked other than

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traumatic event, the Medical Examiner

Director

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21215-0020

Baltimore, Maryland

or Attending Physician: The lew requires that the death certificate be executed for use as certificate this

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• Funeral Hospital

To the I within 2 To the P

P.O. Box 68760

Division of Vital Records,

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Examiner Physician/Medical Completed by Certification: To illed in by

25. Was case ratarrad to medical examiner? 1 Yes 2D No 27. Mannar of Daath 1 | Natural 2 | Accident 3 Sulcida 4 Homicida

29b. Signatura and filla of certifian

29a. Cartifian

5 Panding Invastigation 6 Could not be datarminad

Hospital: 1 patient 2 ER/Outpatient 3 DOA 28b. Tima of

28a. Placa of Injury - At homa, farm, straat, tactory, office building, atc. (Spacify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

12558

28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 certifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

30. Name and address eth (Item 23a) (Type, Print) Mara

29c. Licansa number

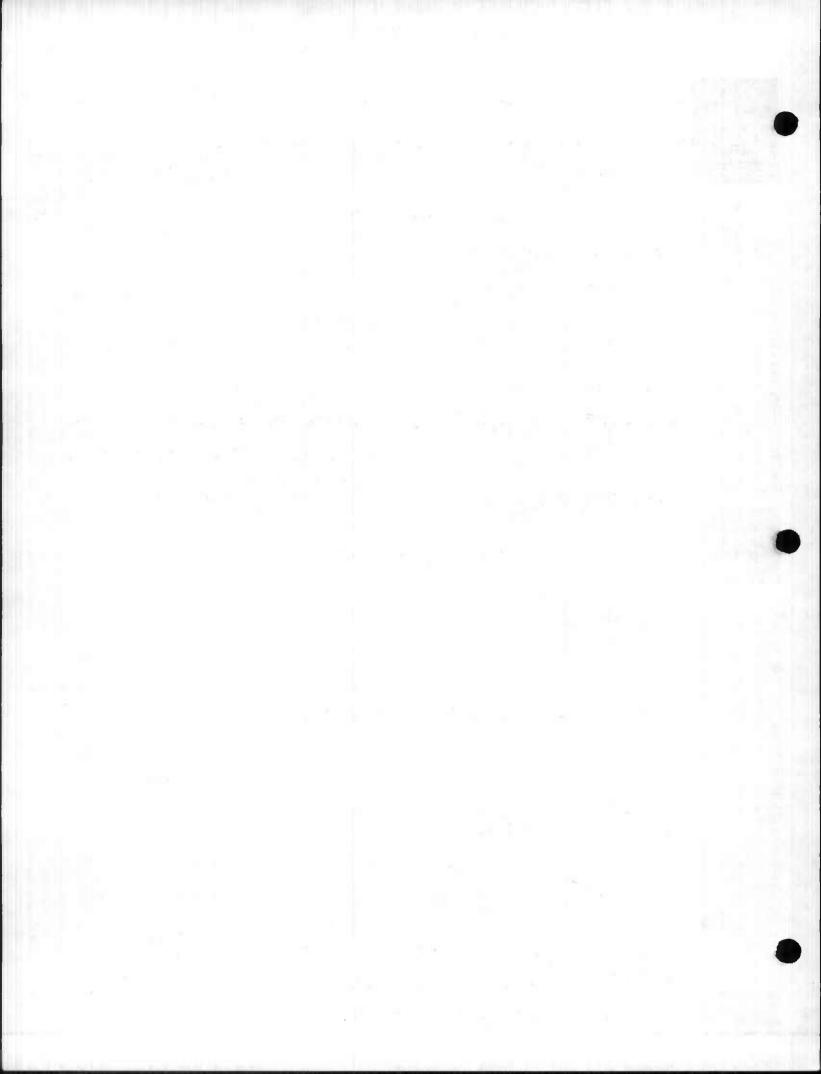
29d. Data signad (Month, Day, Yaar)

State Registrar

Medical

32. Registrar's Signature

Loch Rowen Boulevard



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month 1999 1600 EDWARD ERHARDT AUGUST 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY MARYLAND HOSPITAL OF N/A If Under 1 Year If Under 24 Hrs. 8. Data of Birth Jan. 16, 1938 5. Social Sacurity Number 7. Age (In yrs. last birthday) 6. Sax 9. Birthplace (Stata or Foreign Months Days 1X M 2 F 61 Marialand Vrs 215-34-7787 Usual Rasidence of Decedant 10a. Stete 10b. Count 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Harford Abingdon 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3123 Birch Brook Lane 21009 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 Navar Married 2 Married t X Yas 2 ☐ No If Yas, Giva 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Yeer or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lita. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12th grade Central Office Technician Phone Company 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Henry A. Erhardt Dolores Mullahey 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Alberta W. Erhardt (Wife) 3123 Birch Brook Lane, Abingdon, MD. 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stete 1 Buriei 2 Cramation 3 Ramovai from Stata Dulaney Valley Mem. Gardens 8/13/99 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signeture of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Schimunek Funeral Home of Bel Air, 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death Immediate Causa (Final SEPSIS - FUNGAL diseesa or condition rasulting in deeth) Dua to (or as a consequence of): BILIARY OBSTRUCTION - CHOLANGITIS Dua to (or es a consequança of): Sequantially list conditions, if any, leeding to immadiate causa. Entar Underlying Causa (Disaasa or Injury NON- HODGKIN'S LYMPHOMA that initiated evants rasulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably WUNknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yas 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. fnjury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Yas 2 No

Physician/Medicai by Completed

Examiner sician end burial-transit the 80 for use signed by the a page 2 Be To funeral edical Certification: thef

Physician

/Medical

Examiner

Director

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Physician /Medical

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Physician:

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To the I within 2.

The lew requires that the death certificate be executed

Box 68760.

of Vital Records. P.O.

Division or Attending

Baltimore, Maryland 21215-0020

25. Was casa raferred to medical axeminer?

27. Mannar of Death 1 Netural 2 Accident

3 ☐ Suicida 4 Homicide

29a. Certifier

(Check only 29b. Signature and title of certifian

6 Could not be

MD

28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)

P11538

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

AUGUST

MS. Certifying Physician: To the best of my knowledga, deeth occurred et tha time, date end place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and mannar stated. 29c. License number 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print)

10MAS H. AYALA 31. Data filed (Month, Day, Year)

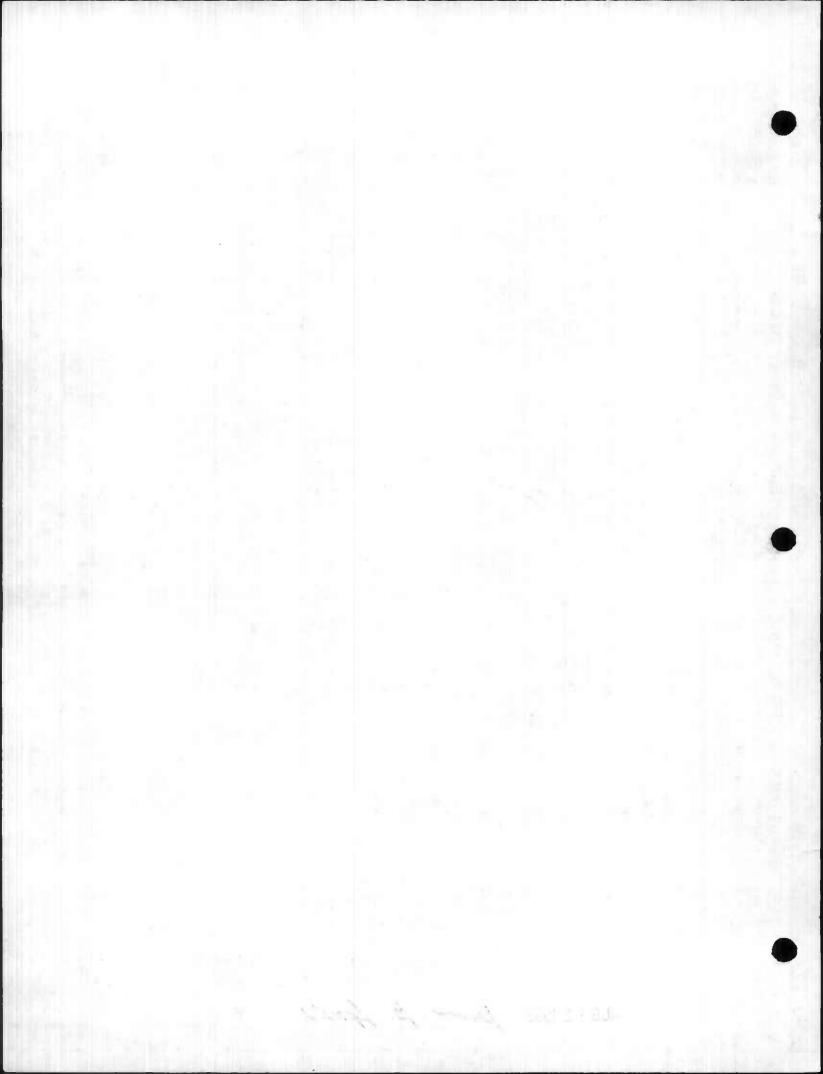
GREENE ST 22 SOUTH

BALTIMORE MD

State Registrar

AUG 1 2 1999

32. Registrer's Signetura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 9 AM AUG-UST Eileen French 1999 1 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) Funeral Deys 1 M 2 XF Hours Months Director 217-46-0777 57 April 18, 1942unknown Usuei Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3101 Juneau Place 21214 unknown Funeral 12. Was Decedent Ever in U.S. Armed Forces unknown 1 □ Yes 2 □ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours effer c. Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Expressional pages. Black, White, etc. 15 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White h 3 ☐ Widowed 4 ☐ Divorced unknown Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h, Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be unknown unknown 19a, Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) unknown 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5X Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Ronald S. Wade State Anatomy Board, 655 W. Baltimore Street nass Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. intervel Between Onset end Deeth **Physician** /Medical Immediate Causa (Final pleura disease or condition resulting in death) weeks Examiner Due to (or as e conseque Examiner ovarian vanced physicien and the burial-transit Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or as a consequenca of): 80 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown mone by 24b. Were autopsy findings aveileble prior to completion of cause of death? 24e. Was an autopsy performed? Completed certificata has 2 DINO 1 Yes 2 No 25. Wes cese referred to medicet exeminer? Be 26. Place of Death (Check only one) Hospitei: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of tnjury (Month, Dey Year) funeral 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending Investigation 1 Meturel 1 Tyes 2 No 2 ☐ Accident after death Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated. edical (Check only one) 2 Medicel Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. To the I Washos 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Dete filed (Month, Dey, Year)

AUG 1 1 1999

UNION MEMORIAL

HOSPITAL, 201 EAST UNIV. PARKWAY, BALTIMORE 32. Begistrer's Signeture

Second year resident; OBIGYN AT2438946 Aug
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANTOUN KHABBAZ, M.D.

AT2438946

Hugust, 1

the Meryland

death

3altimore, Maryland 21215-0020

certificate be executed

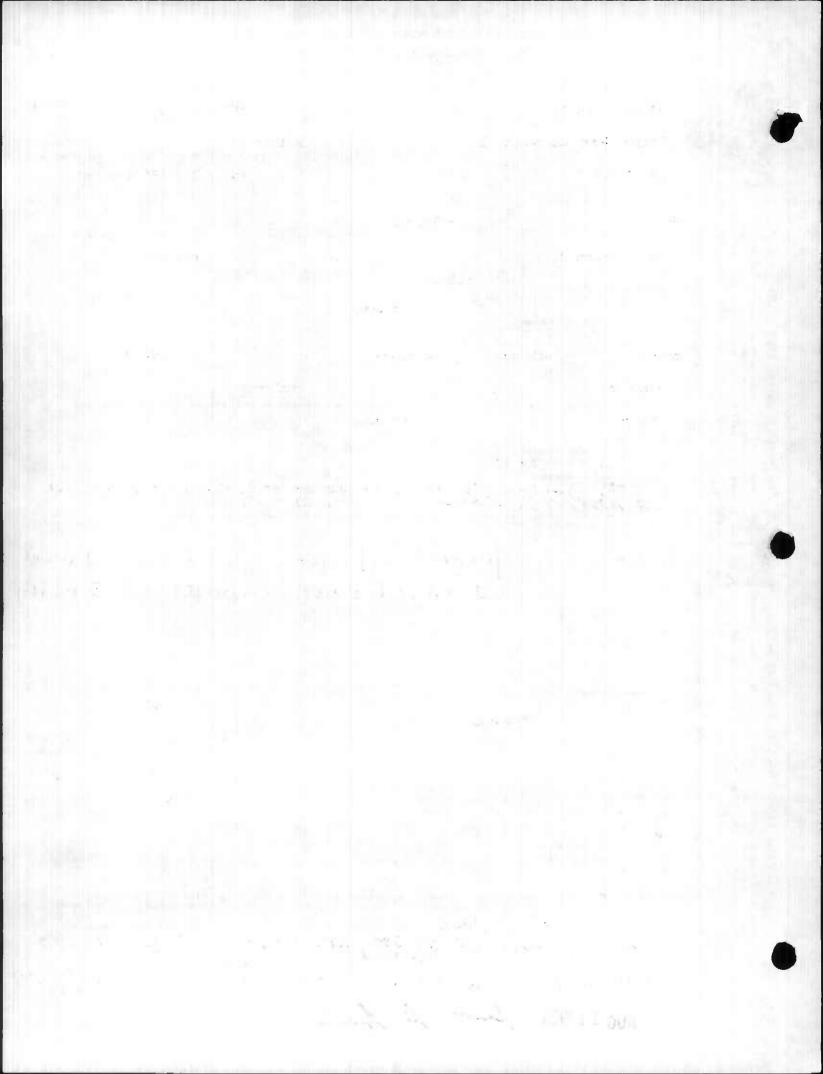
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Division of Vital

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Hospital 24 hours a



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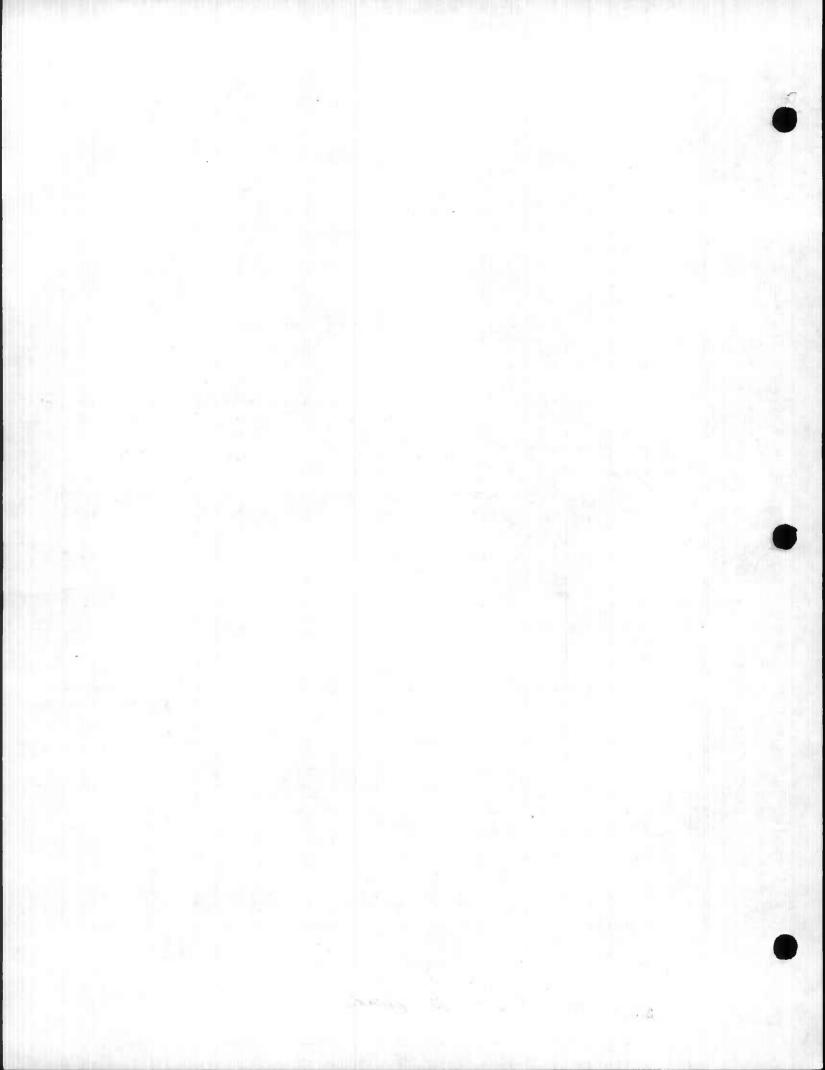
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedenl'a Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death AUGUST 11, 1999 Physician BERNHARD GORDON 5:35 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner PIKESVILLE NURSING HOME BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) UNE 23, 1908 6. Sex 1 ⋈ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 215-03-9783 91 Yrs. GERMANY Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryla: the Medical Examiner must be notified at N/A BALTIMORE MD 1 X Yas 2 No Director Name 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6317 PARK HEIGHTS AVENUE #219 U.S.A. 21215 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, atc. Illed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ъ 21215-0020 1 ☐ Yes 2 ☑ No Specify: WHITE þ Specify: XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) RETAIL **JEWELER** Saltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 88 permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 is marked or UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code,NC 28605 19a. Informant's Name/Ralationship (Type, Print) ALAN F. GORDON / SON P.O. BOX 2365 - 395 MOCKINGBIRD LANE - BLOWING ROCK, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stete NGBurial 2 ☐ Cremation 3 Maemoval from State 4 ☐ Donalion 5 ☐ Other (Specify) ò 8/11/99 RIVERSIDE CEMETERY ASHEVILLE, NC 21. Signature of Fupural Service License 22. Nama and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ar the disease, or complications and aused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, heart failure. List only one cause of aach line. Approximata Interval Between Onset and Deeth **Physician** Immediate Causa (Final disease or condition rasulting in death) Examiner Examiner The law requires that the death certificate be axecuted burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760. ed by the attending physician detached for use as the buria Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. s been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown À 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? has this certificate 1 ☐ Yas 2 ☐ No after death.

Office of the continue of the co funeral director, Be 25. Was casa referred to medicat axaminar? 26. Place of Daath (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 9 ited cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year) AUG 12 1999 6804



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Pat	ricia S AMEND#2	3a8	Gardner &27 PER M.E.O. G777 1	State of M 11-24-99 J.A.	-	_	artment o			Mental H	ygiene Reg. No.	99	25	313		
	Physicia /Medic		Decedent's Name (First, Middle, L PATRICIA		RDNE	R				2. Date of I Month Augus	Day	, 199	ear	Tima of Death : 02 A.M.		
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	Funeral Director		218-82-1761		Room ge (In yrs. 36	40 / last birthday) Yrs.	If Under 1 Y Months De		Baltima If Under 24 Hr Hours Mir	s. 8. Date of I	Birth Day Year)	N/A 1962		a (State or Foreign		
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020	72 hours after death with the Maryland naturer, or thems 23s or 28s-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		Was Decedent f Yes, specify (panic Origin? (, Mexican, Pue Specify:	Specify Yes or ro Rican, etc.)		Bleck,	American I White, etc.	indian,		
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Ma	d d d d d d d d d d d d d d d d d d d		19a. Informant's Name/Relationship LAURA WILLIAM		ER					Rural Route Num	-		21205			
0	of He r		20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Spec	☐Removel from State	20b. P	tece of Dispo	sition (Name of natory or other MEM . (f place)	Date	20c. Lo	cation - Ci	on - City or Town, State 99 Balto, Md.			
Balt	permit. Pag Department Important: I any Injury o		21. Signatur of Juneral Service Lin	TO TO				I B	. SCRI	JGGS FI	UNERA	AL HO	OME	21213		
	hysician /Medical		23a. Part 1. Enter the disease, of conshock, or heart failure. List onl	nolications that cause y one cause on each li	CARDIA	h. Do not ent	er the mode of	dying.	such es cardia	SPLASIA A	arrest,		Ap	proximate erval Between eset and Death		
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,00	rate be executed hysician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or as a consequence of):											
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E B	Tha Tha Sata ha	Cod								1,5	Yes 20	□No	1000	es 2 No		
Vita	2 50	e Be	25. Was case referred to medical exeminer?	Hospital:		CD10		Other		eath (Check on	y one)		10			

To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ci completely filled in by the funeral dire Medical Certification: To Division of

27. Menner of Death 1 Natural
2 Accident

5 Ponding investigation

28a. Dete of Injury (Month, Day Year) 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

6 Dother (Specify) at scene

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29a. Certifier (Check only one) 29b. Signature and title of certified

3 Sulcide

4 Homlcide

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) August 08, 1999

of death (Item 23a) (Type, Print) 30. Nama and address of person who co

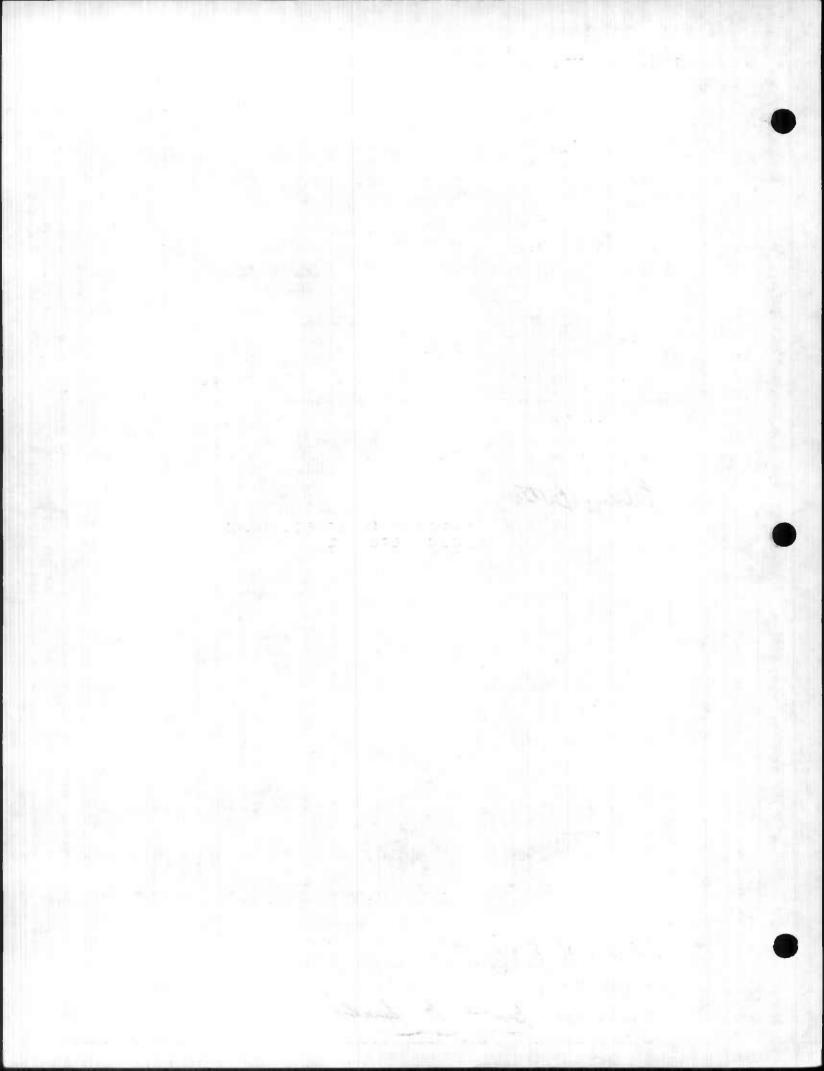
THETPORE Mc King 31. Date filed (Month, Dey, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signature

DHMH 16 Ray 6/95



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Registrar DHMH 16 Ray 6/95

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31. Dete filed (Month, Day, Year) .

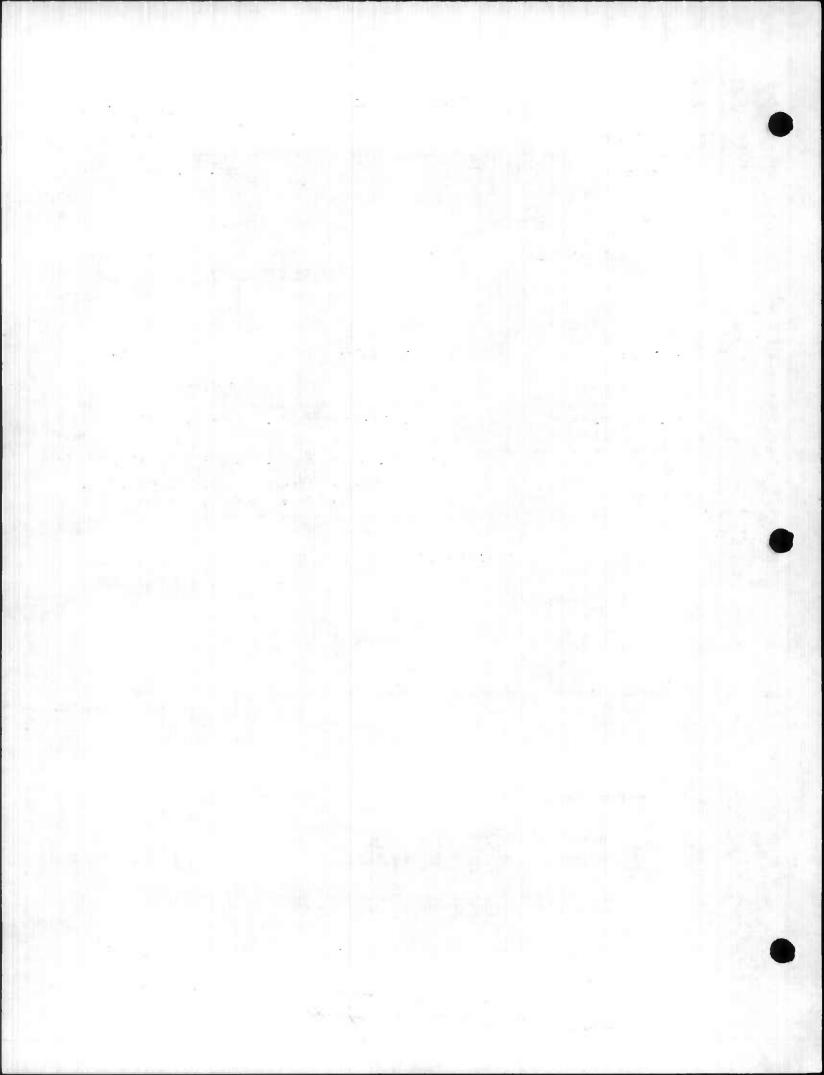
MARY

HARRISON,

NAME:

32. Registrac's Signature

Timonium, Md 21093



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

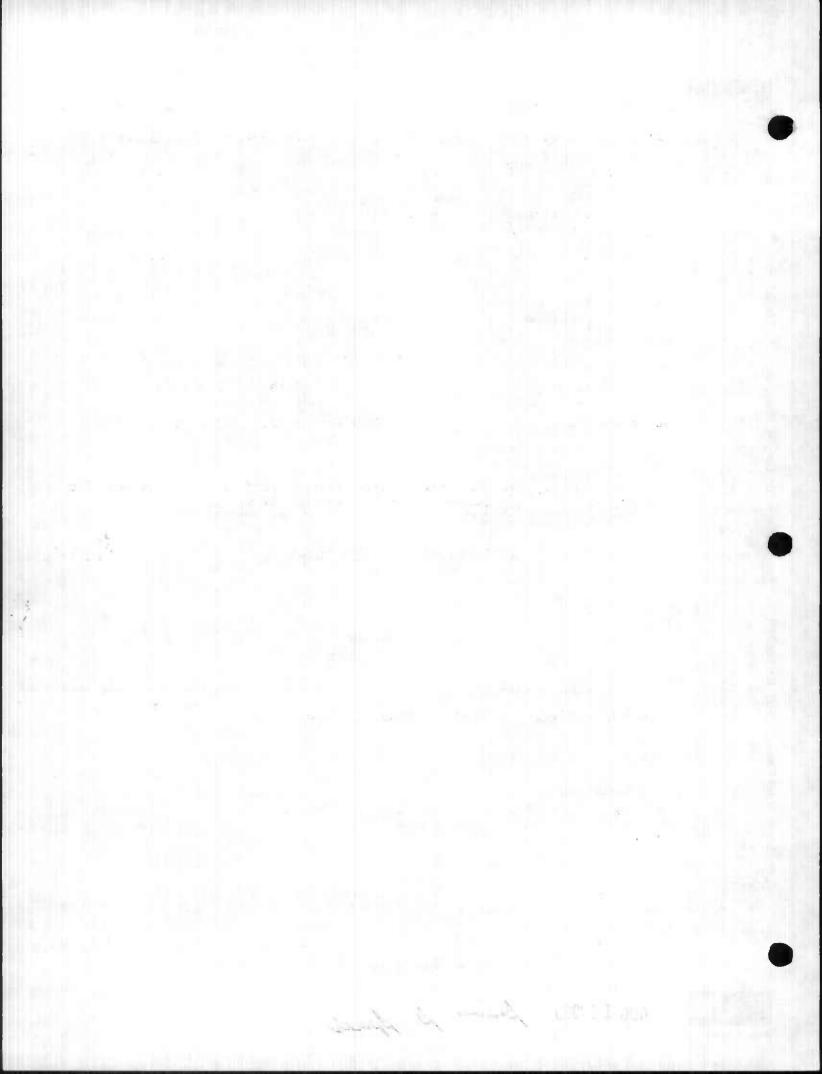
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Year **Physician** Marguerite R. 6 1999 6:50 am August /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Allegany County Nursing Home Cumberland 7. Age (In yrs. last birthday)
93 Yrs.

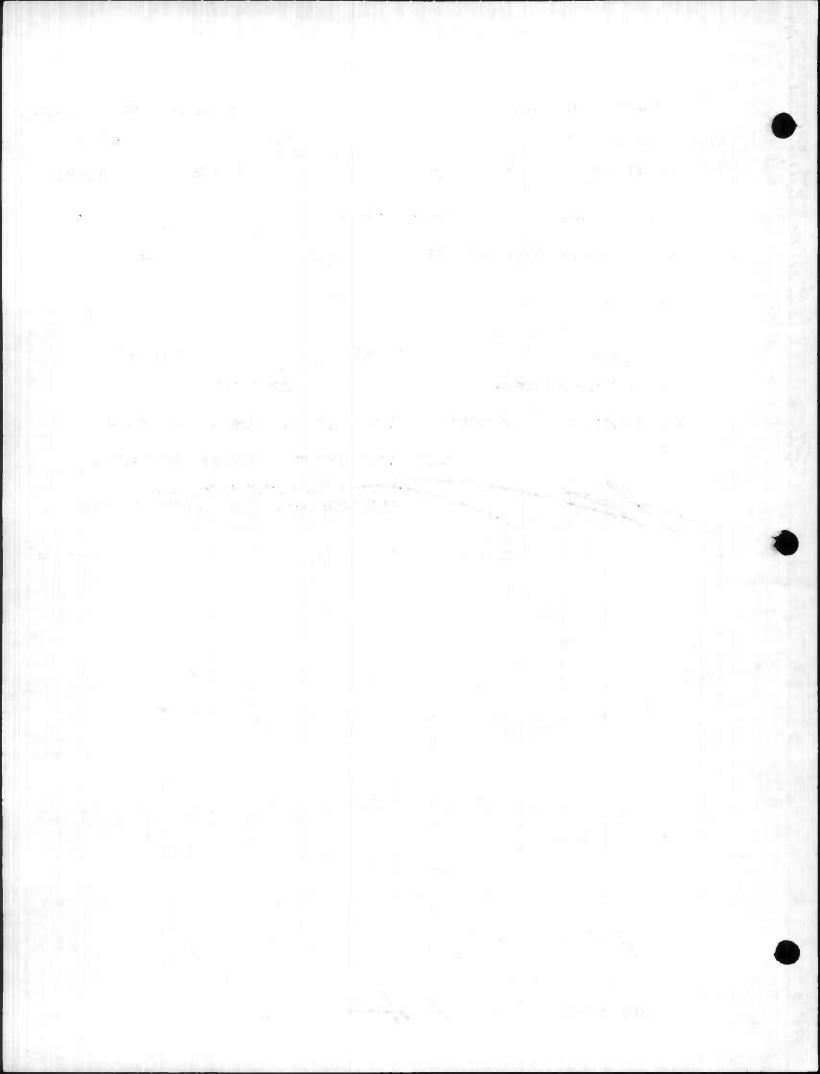
| Months | Days | Hours | Min. | Sept. 28, 1905 Allegany Birthplace (State or Foreign Country)
 KY **Funeral** 1 M 2 F Director 215-26-9734 Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Allegany 1 ☐ Yes 2√ No Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 210 Baltimore Avenue 21502 U.S.A. deeth v Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours efter dail Hygiene. other than "natural", or item 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home .. Pages 1 and 2 should be filed vitinant of Health and Mental Hygie tant: If item 27 is marked other toury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be John Robinson Cora unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo Brandon/son 7918 Charlesmont Rd., Baltimore, MD 21222 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removei from State permit. Page Depertment of Important: If any Injury or once. 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald S., Wade, Director State Anatomy Board, 655 W.

Baltimore, MD 21201

23a. P. nl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. State Anatomy Board, 655 W. Baltimore Street **Physician** /Medical Immediate Ceuse (Finel & ALZHEIMENS DEMENTIA 69RS disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): attending pl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE LUPG DISERSE Division of Vital Records. 24b. Were eutopsy findings aveliable prior to Completed 24e. Wes en eutopsy completion of cause of deeth? certificeta has t lirector, paga 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 No or Attending Physician: director, 25. Was case referred to medical 28. Place of Death (Check only one) Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturai 5 Pending after death. 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end manner es steled.

| Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steled. Medicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Vomera AUG. 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) BARRENA JA 31. Date filed (Month, Day, Year) 12. Registrar's Signeture State AUG 1 1 1999 B. Spark Registrar

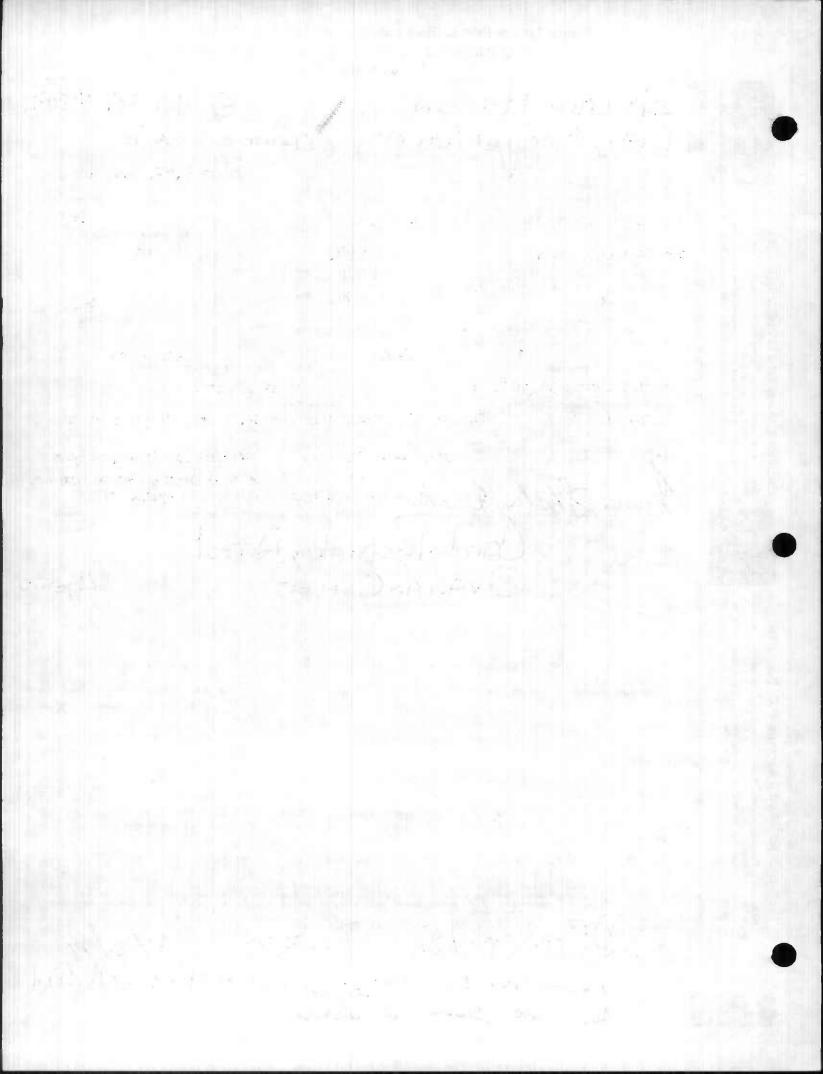




Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death rooth 120P14 **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Name (If not Institution, giva street and number) Examiner +1001e ndar 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Sacurity Numb 6 Sax 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 220-50-3474 Yrs. 51 Director January 23, 1948 Maryland Usual Residence of Dacedent the Meryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at Yes 2□No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 504 East Lake Avenue 21212 USA 2 should be filled within 72 hours after death vin and Mental Hygiene.
Is marked other than "natural", or flame 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Datas: 14. Race - American Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 11 Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes XXNo Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Patrick Joseph Coughlin Jr Winifred Lynch 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 ia m P.J.Coughlin Jr Father 5220 Springlake Way Baltimore, Maryland 21212 20a. Method of Disposition
1 ☐ Burial 2 CACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 8/12/99 Baltimore, Maryland any Injury o Greenmount Cemeterv 4 □ Donation 5 □ Other (Specify) 22. Name and Addrass of Facility ature of Funaral Service Licenses Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or compilcations shock, or heart feilure. List only one ceuter the mode of dving, such as cardiac or respiratory arrast. Approximate Interval Between Onsat and Daath **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to Examiner the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue that the death certificate be exec Box 68760 physicien Physician/Medical Due to (or as a consequence of): 80 USB for Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown signed by þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed page 2 certificate hes 2 ALNO 1 ☐ Yas 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Day Year) luneral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After t Natural or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death Director: 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide hours e 24 hours Hospital 10 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai completely (Check only one) within 2 the 29b. Signature 29d. Date signed/(Month, Day, Year) 0 30. Name erid erson who completed cause of death (Item 23e) (Type, Print) 501 St. Paul Merch Med. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

AUG 12

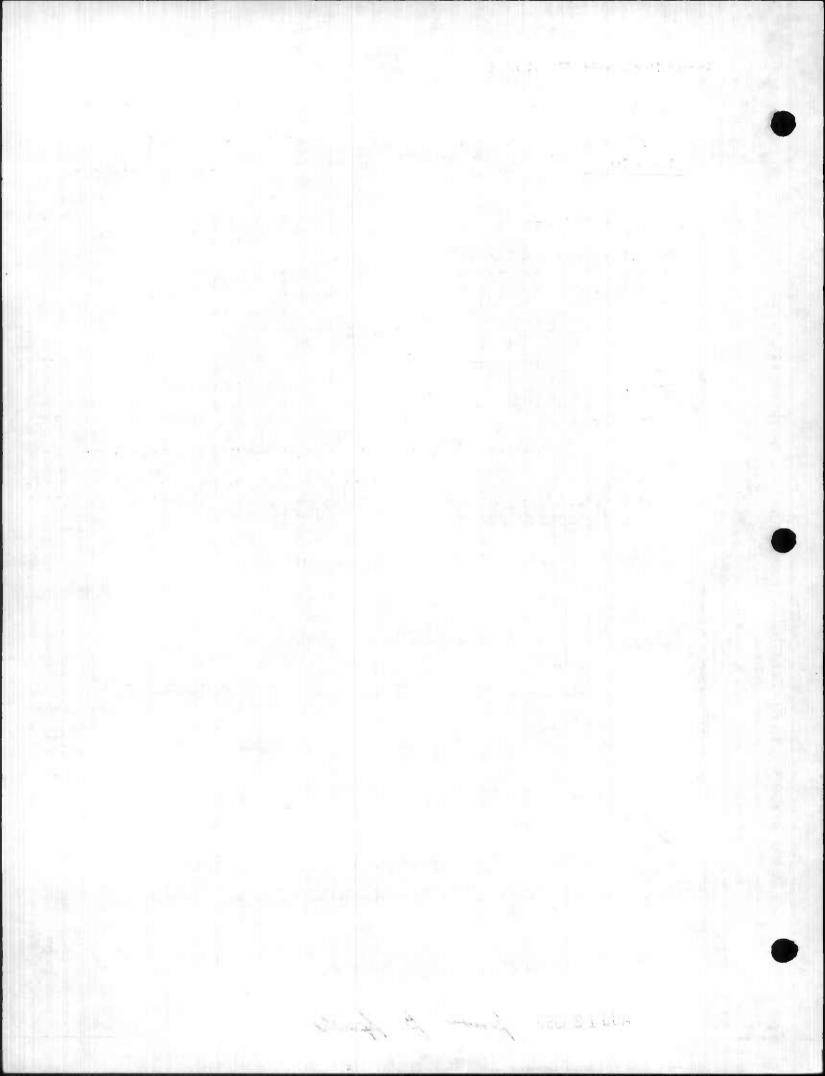


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#5 perFH G774 8/16/99 EW Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Year Physician Elsie V. 08 09 1999 1:30 A.M /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Yrs Director 01 09 29 1901 Virginia Usual Residence of Decedant with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 709 Maiden Choice Lane. 21229 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. hours efter 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: à 3 ₩ Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry i filed within 7. I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 11th Teacher Education le marked other 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 ie marked oth-eny Injury or other traumatic evem Be Ernest McPherson Maude (Slusser) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22506 Parker Creek Rd. Harry Hart/ Son Parksley, VA 23421 20a Mathod of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter, cremetory or other place)
Baltimore/Washin. Cre8/11/99 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Laurel, MD 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility
Sterling-Ashton-Schwab Funeral Home Inc 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feitura. List only one cause on each line. Edmondson Ave. Catonsville, MD 21228 Approximate Intarval Between Onset and Death **Physician** /Medical tmmediate Cause (Finel disease or condition resulting in death) vasaular Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last Dua to (or as a consequence of): ettending physician for use as the burie P.O. Box 68760, Physician/Medical Dua to (or es a consequence of) been signed by the should be deteched Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part It. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yas 2 No certificate 1 ☐ Yes 2 2 No Division of Vital To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funerel Director: Affer this certifical completely filled in by the funeral director; 25. Was casa refarred to medical Be 26. Place of Death (Check only one) Other: Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Tima of 1 Netural
2 Accident 5 Pending invastigation 1 ☐ Yes 2 ☐ No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edicai 29e. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and menner as stated. (Check only one) 2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and sidrass of person who completed cause of death (Item 23a) (Type, Print) My a M Oos 31. Date fied (Month, Day, Year) Maiden Charge Lane Catonsville Mr Carporter MD 115 32. Registrar's Signature State

Registrar

AUG 1 2 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 253 | 9

		Certificat	e of Death		Reg. No.				
1. Decedent's Neme (First, Middle	Last)			2. Dete of D		3. Time of Death			
Medical BERTHA FRE	DA HOLS	TE		Month -	11 - 9°	5:35AM			
aminer 4s Facility Neme (If not institution			4b. City, Tov	wn, or Location of Dea	ath 4c. County of E				
	E ELDERCA	RE	N	1/19	BALTI	MARE			
5. Social Security Number	6. Sex 7. Age (In yrs.		1 Yeer If Under 2	24 Hrs. 8. Date of 8		Birthplace (State or Foreign Country)			
Usual Residence of Decedent	1□ M 20%F 97	Yrs.	Days Hours			PARYLAND			
10a. State 10b. County MARYLAND BALTIN 10e. Street and Number 1721 WENTWORT 11. Merital Status 1 Never Merried 2 Marris 3 Widowed 4 Divorced	10c. Cit	y, Town or Location				10d. Inside City Limits			
& MARYLAND BALTIC	NORE PAR	KVILLE				1 ☐ Yes 2 No			
10e. Street and Number		10f. Zij	Code		10g. Citizen of Wha	t Country?			
	H ROAD	2	234		UNITED S	rates Of America			
11. Merital Status 1 Never Merried 2 Marrie	12. Wes Decedent Ever in U. Armed Forces?	S. 13. Was Dece	dent of Hispenic Orig	gin? (Specify Yes or N , Puerto Rican, etc.)		American Indian,			
1 Never Merried 2 Married 3 Widowed 4 Divorced		1 ☐ Yes		, Puerto Rican, etc.)	100	Vhite, etc. UHITE			
15. Decedent	s Education	16a. Decedent's Usu	al Occupation	ad undrine	16b. Kind of Busine	ess/Industry			
(Specify only highest	College (1-4or 5+)		rk done during most se retired)	or working	5 AND D	ime STORE			
5 9TH GRADE		SALESLA	DY		J THE C	THE CHORE			
17. Father's Neme (First, Middle, L	T T			r's Neme (First, Middle	·				
e AUGUST WIED	ENHOEFT		MAR	Y O'TREN	nBA				
19e. Informent's Name/Retationsh WILFRED HOLST			Street and Number		ber, City or Town, Ste	te, Zip Code) 2YLAND 21234			
20a. Method of Disposition	20b. P	lece of Disposition (Ne	me of	Dete	20c. Location - City	or Town, State			
1 Buriel 2 Cremation 4 Donation 5 Other (Sp		emetery, crematory or C		Aug. 13, 199	BALTIMON	RE, MARYLAND			
21. Signature of Funerel Service L						7			
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230 Baril Enter the disease of	Mentry Doood	2 6009	HARFOR	D Road E	BALTO, MD	2/2/4- Approximate			
	omplications that suised the death	i. Do not enter the mo.	ie of dying, such as	cardiac or respiratory	arrest,	Intervel Between Onset and Death			
Immediate Cause (Finat	A =				1.	- File-			
disease or condition resulting in death)	· ATHEROSCLE	ROTIC CA	RDID VASC	WHAR I	ISEASE	75YRS			
	Due to (o	r as a consequence ot)							
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Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to (o	r as a consequence of)							
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Cause (Disease or trijury that initiated events resulting in death) Last	Due to (or	es a consequenca o1):							
	d					1			
Part II. Other algnificant condition									
Part II. Other significant condition	s contributing to death but not resu	ulting in the underlying o	ause given in Pert I.	23b. Di	d tobacco uss contril	outs to the cause of death?			
DEGENER	PATWE JOIN	10	1 Yss 2 No 3 Probably 4 Unknown						
8						4b. Were autopsy lindings			
<u> </u>				per	formed?	available prior to completion of cause of deeth?			
Completed					1700 000				
					Yes 2 No	1 ☐ Yes 2 Ø No			
25. Wes case referred to medical examiner?	Hospitat:		Other:	of Death (Check onl)					
1 Yes 2 No	1 LI Inpatient 2 LI	ER/Outpetient 3 De	DA 4LI NUI	-	sidence 6 Other	Specify)			
5 1 ☑Natural 5 ☐ Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of fnjury	28c. Injury at Work?	100000	e how injury occurred				
2 Accident investig	1he			Yes 2 No					
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investige 6 Could nedeterming	ed 28e. Placa of Injury - At he building, etc. (Specif)	ome, ferm, street, fector v)	y, office	City or T	own, State)	er Rurel Route Number,			
29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best of my know karminer: On the basis of examinet and menner steted.	wledge, death occurred tion and/or investigation	at the time, date and , in my opinion, deat	d place, and due to the th occurred at the time	e cause(s) and menne e, date end pleca, and	or as stated. due to the cause(s)			
29b. Signa/Ore and title of certifier	and monner stated.	29	c. License number		29d. Dete signed (A	fonth, Dey, Year)			
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riginon	uyu '		4004	0	rugusi	111799			
30. Name and address of person w	ho completed cause of death (Item	23a) (Type, Print)	7.	. 11 2 . 1	- D -	1 11001			
KAMA SHAW	401-10	Model	- Miver	Weck	- Koa	41491			
State 31. Date filed (Month, Day, Year) Strar AUG 12 19	32/Registrar's Signa	ture & La	121						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death August 10, 1999 **Physician** Philip L. Houck 10:30 p.m. /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11200 Thompson Ave. Reisterstown Baltimore If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Dete of Birth
(Month, Day, Year)
July 7, 1918 9. Birthplace (State or Foreign **Funeral** Maryland Deys 213-01-2376 10XM 2□ F 81 Months Hours Director Usuel Residence of Decedent 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits show with the Maryla 1 Yes 2 No Md. Baltimore Reisterstown Director 288-1 the Medical Examiner must be notifi-10e Street and Number 10g. Citizen of What Country? 10f. Zio Code harns 23a or 11200 Thompson Ave. U.S.A. 21136 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 Aves 2 No Hyes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 72 hours after 1 Never Merried 2 Married 21215-0020 ò 1 Yes 2 No Specify: Specify: White WW II þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiere. filed within College (1-4or 5+) Elementary/Secondery (0-12) Commercial Construction Operating Engineer Saltimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be I nent of Health and Mental I int: if litern 27 is marked of Minnie Lages William Y. Houck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11200 Thompson Ave., Reisterstown, Md. 21136 19a. Informent's Neme/Relationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other tras Beatrice Houck - Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other p 20e. Mathod ol Disposition Dete 20c. Location - City or Town, State cometery, cremetory or other piece)

Evergreen Mem. Gardens Aug. 13, 1999 Finksburg, Md. Burlal 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 21. Signeture of Fungrel Service Licenses 22. Name end Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 23a. Part1. Enjer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, of heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) ereb novascol Acc, le Examiner Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical Due to (or es a consequence of): signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy lindings evailable prior to completion of cause ol death? 24e. Was an eutopsy performed? Completed 1 Yes 2 ₽No 1 Yes 22 No To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 critifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and mannar as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reistenton Minkeye

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State Registrar

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

505 Mosher St., Balto.City, MD

JUNE 16, 1999

	Certificate of Deal 1. Decedent's Nama (First, Middle, Last)	2	. Date of Dea	th		3. Tima of Death						
sician	Donald King		Month JUNE 15	Day	Year	2:55 PM.						
dical niner		, Town, or Loca		7	y of Death							
	505 MOSHER ST. BA	ALTIMORE	Ξ									
	Months Days Hour	dar 24 Hrs. 8	. Dete of Birth (Month, Day	Year)	9. Birthpla	ace (State or Foreign ry)						
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	21. Signeture of Junaral Sarvice Licenses Ronald S Director State Anatomy Baltimore, MD 23a. Part I. Entar tha diseasa, or complications that caused the death. Do not enter the mode of dying, such anock, or heart failure. List only one cause on each line.	Board, 21201				St. Approximate Interval Between Onsat and Death						
	Immediata Causa (Final disaasa or condition a. Narcotic Intoxication rasulting in daath)											
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Examiner	b				i							
Exa	Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury c.				1							
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-	resulting in deeth) Last				i							
Physician/M	and II. Other significant conditions contributing to doubt but not resulting in the underbying cause gives in D	lod I	23h Did to	obecco use o	patribute to	the cause of death?						
hys	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of the c											
by			24a. Was a	a autoneu	24b Wai	ra sutopsy findings						
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du			.777	• • • • • • • • • • • • • • • • • • • •		eath?						
ဝိ	25. Was case referred to medical 26 PI			as 2 No	1X	Yas 2 No						
o Be	examiner?	Placa of Death (has (Cassibe	VACANT						
-	27. Manner of Death 28a. Data of Injury 28b. Tima of 28c. Injury at			ow injury occu		HOUSE						
Certification:	2 Accident investigation 1 (1) (10) 1 M 2271 Yes 2	2 No	Unknow	n								
IIIC	3 Suicide 6 Could not be 28a. Placa of injury - At homa, farm, atreet, factory, office		f. Location (S	treet and Num	ber or Rural	Route Number,						
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O	House Building. atc. (Specify) City or Town, Stata) House 505 Mosher St., Balto.City, I											
edical C	29a. Cartifiar (Check only one) 1 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, (and manner stated.)											

State Registrar

111 Penn Street, Baltimore, Maryland 21201 Pestaner, M.D. Joseph P. 31. Date filed (Month, Day, Year)

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

32 Registrar's Signatura AUG 1 1 1999

O.C.M.E.

AUG. 1 1 1992 - -----

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

4115110		050 450044 0500				-	artment ertificate			Mental H	ygiene Reg. No.	0 0	5222		
Physic		1. Decedent's Name (First,						2. Data of I	Death Day	Year	3. Time of Death				
/Medi Examir		4a Facility Name (If not ins		ve street and nu				1	lb. City, Town, o		Location of Death 4c. County of Death				
Funeral Director		Oak Crest 5. Social Security Number 216-07-1514		Center Sex 10 M 20 F		i. last birthday, Yrs.	Months	1 Year Days	Perry H	rs. 8. Deta of E (Month, I	Birth Day, Year) 3, 190		re hplace (Stata or Foreign nuntry) ryland		
P		Usual Residence of Deced			10c. C	ity, Town or L	ocation						t Od. Inside City Limits		
Meryler 4 show	ŏ		ltimo	** 0									t ☐ Yas 2 ☑ No		
deeth with the Meryland ms 23a or 28a-f show	Director	10e. Street and Number			re	erry Ha	10f. Zip (Code			10g. Citizen of What Country?				
5 22	by Funeral	8832 Walt] 11. Marital Status 12 Never Married 20 3 Widowed 4 Dh] Married	7	2 No ve	U,S. 13.	Was Decede	fy Cubi		(Specify Yes or the orto Rican, etc.)	14.	Race - Ama Black, White	e, atc.		
Maryland 21215-0020 d 2 should be filed within 72 hours effer th end Mental Hyglene. The marked other than "natural", or its troumatic event, the Medical Event in the Medical Event in the Medical Event in the Medical Even	Completed		1	ducation ade completed) College ((Give	dent's Usual kind of work DO NOT use	done o	during most of w	rorking	16b. Kind	of Business/	Industry		
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Baitimore, M pemir. Peges 1 end 2 Department of Heelth Important: if Hem 27 is any injury or other tre once.		20a. Method of Disposition 1 Burial 2 Crem 4 Donation 5 Ot			complete cromplete or other place)						20c. Local	20c. Location - City or Town, Stata			
Bait. Department. Department. Importu		21. Signature of Fuheral Se Rot		S. Wede	Direc	tor S		lnat			, 655 W. Baltimore Street				
Physician ele pe peculiar production elle permission elle principular principu	Examiner	Immediata Cause (Finel disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury)	<u></u>	a. PN		ONLA (or as a conse	quence of):		9			9 2 3 1 1 2 3 1	Onsat and Death		
deeth certificate estending physed for use as the	sician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last	l	d		or as a consec		use giv	en in Part I.	23b, Di	d tobacco ua	e contribute	to the cause of death?		
D de by	y Phy	Advance	d d	emon	tia					10	Yes 21	No 3□P	robably 4 Unknown		
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		25. Was case referred to m	teriha	Ī					ne Diana of D		Yas 2/04	No	1 Yas 2 No		
of Vita Physician: this certific	To Be	axaminer?	OUICEI	Hospitat:	Inpatient 2	TER/Outputio	or 3□ DO	Oth	00	leath <i>(Check onl</i>) Home 5□Re	4 1/2	Other (Sne	city)		
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Division of Attending s effer deeth. If Director: After	Certification:	3 Suicide 6 0 4 Homicide	Could not t letarmined	28e. Place build	of Injury - At I ing, etc. (Spec	nome, farm, st	reet, factory,	office			(Street and fown, State)	lumber or Ru	ural Routa Number,		
Division Within Education within Education and the Complete of the Funerel Director:	edical (29a. Certifier 1 Ce (Check only 2 Me	rtifying Pl dical Exa	miner: On the b	best of my kn asis of axamin ner stated.	owledge, deat ation and/or in	th occurred at evestigation, i	t the tin	ne, date and pla pinion, death oc	ce, and due to th curred at the time	e cause(s) an e, data and pl	d manner as ace, and dus	s stated. a to the cause(s)		
withi To th	Σ	29b. Signature and title of o	ertifier	\sim			29c.	License	e number		29d. Data s	igned (Mont	h, Day, Year)		
		30. Name and address of p	ell!	completed caus	ler de denth the	ens	Print)) 2	564	3	07	128/	199		
		31. Deta filed (Month, Day,	es	MD 88	100 W	althe	~Blu	d	But	nor	MD	913:	34		
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3. Time of Death

1999

JULY

Physician /Medical Examiner **Funeral** Director

JOHNA KESSLER

4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL SYSTEMS BALTIMOLE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number Days 10M 20 F Months 226-32-6104 Usuel Residence of Deceder Sept. 4, 1929 Virginia Marylend 10a, State 10b Count 10c. City. Town or Location 10d. Inside City Limits r than "natural", or hama 23a or 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD A.A Brooklyn Park eg th 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 316 Fifteenth Ave. 21225 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? \(\) Yes 2 \(\) No If Yes, Give Year or Dates: \(\) W. W. II Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 72 hours after Maryland 21215-0020 1 Yes 2 No Specify: Specify py 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. W. R. Grace Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed w th and Mental Hygier 7 is marked other th Supervisor Chemical Co. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If Itam 27 is marked of any Injury or other traumatic av WILLIAM E. KESSLER THELMA HESSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Geraldine Kessler, wife 316 Fifteenth Ave., Brooklyn Park, MD 21225 Baitimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery
22. Name and Address of Facility 7/31/199 Baltimore, MD 21. Signature of Funeral Service Licenses George J. Gonce Funeral Home, PA 236. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

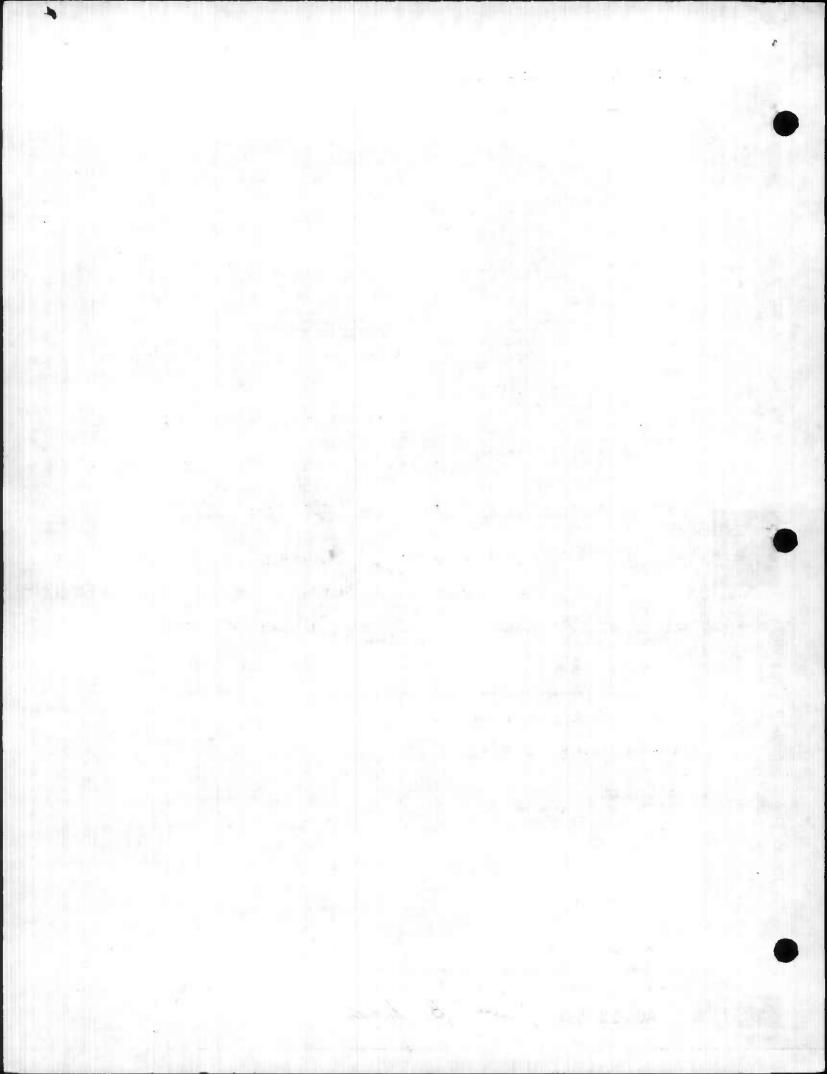
Approximately a such as cardiac or respiratory arrest, Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical MULTI ORGAN SYSTEM FAILURE Examiner Due to (or as a consequence of): 118 -> 54 HAN 6 GRAM NEGATIVE ROO SEPTIC SHOCK physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760 CINTRAABOOMWAL SEPSIT ! UREMIA Physician/Medical Due to (or as a consequence of) 180 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? P.0. signed by t 1 Yes 2 No 3 Probably 4 Onknown END STAGE REWAL DISPASE Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed DISEASE CHROMIC LIVER completion of cause of death? page 2 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? or Attending Patter death. After 1 DiNatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier pletely (Check only one) within 2 To the 29b. Signatifie and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. D WASA 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEPT OF ANETHESIOLOGY, UMMS BALTIMORE EVELYN ANSA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

AUG 1 2 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month George Elmer Knight, Sr. 2:35 PM August 7, 1999 4e. Facility Neme (If not instifution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Westminster Carroll County General Hospital Carroll 7. Age (In yrs. last birthdey) | If Under 1 Yeer | If Under 24 Hrs. | 8. Deta of Birth | Months | Deys. | Hours | Min. | (Month, Dey, Year) 5. Sociel Security Number 6. Sex 10 M 2□ F Birthplece (State or Foreign Country) Yrs. 215-09-4074 February 22, 1919 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21157 U.S.A. 292 Winterberry Lane 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: 194 11. Maritel Stetus 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck. White, etc. 1 ☐ Never Merried 2 ☐ Merried 1943 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 1945 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Contracting Eiamantery/Secondery (0-12) College (1-4or 5+) 10 Contractor 17. Father's Neme (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Surnama) John Nicholas Knight Pearl Anne Selby 19a. Informant's Neme/Raietionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 7886 Corner Stone Way Baltimore, Maryland 21244 Mr. William Knight Son 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriei 2 Cremetion 3 Removei from State 08/11/99 Ellicott City, Maryland Good Shepherd Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Slack Funeral Home, P.A. 23a. Pert / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each lina. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximete Intervei Batween Onset end Deeth Immedieta Cause (Finei . Small Bowel obstruction diseese or condition rasulting in deeth) Hepatorenal Syndrome Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

inding physician and use as the bunal-transit

signed by t

this

To the Hospital or Attanding P within 24 hours aftar death. To the Funeral Director: After t

Records, P.O. Box 68760.

Division of Vital

Physician

/Medical

Examiner

Director

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Funeral

Director

r than "natural", or lisms 23s or 28s-f show the Medical Examiner must be notified at

nd Mental Hygiene. marked other than

Pages 1 and 2 should be I thrient of Health and Mental I riant: If Item 27 is marked or

altimore. Maryland 21215-0020

Sequentielly tist conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that he had been and the cause (Disees that Initiated events resulting in deeth) Lest

Physician/Medical Pert It. Other significant conditions confributing to death but not resulting in the undarlying cause given in Pert t. End stage cinthosis 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Congestive Heart failure 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case raferred to medical examinar? 26. Piaca of Death (Check only ona) Hospital: 1 Interpretation 2 □ ER/Outpetient 3 □ DOA Othar: 4 Nursing Home 5 Rasidance 8 Other (Specify) 1 Yes 2 No 2 27. Menner of Deeth 28a. Date of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturei 5 Panding Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 - Homicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner es steted.

2 Madical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the fime, defe end piece, end due to the cause(s) and menner stated. (Check only

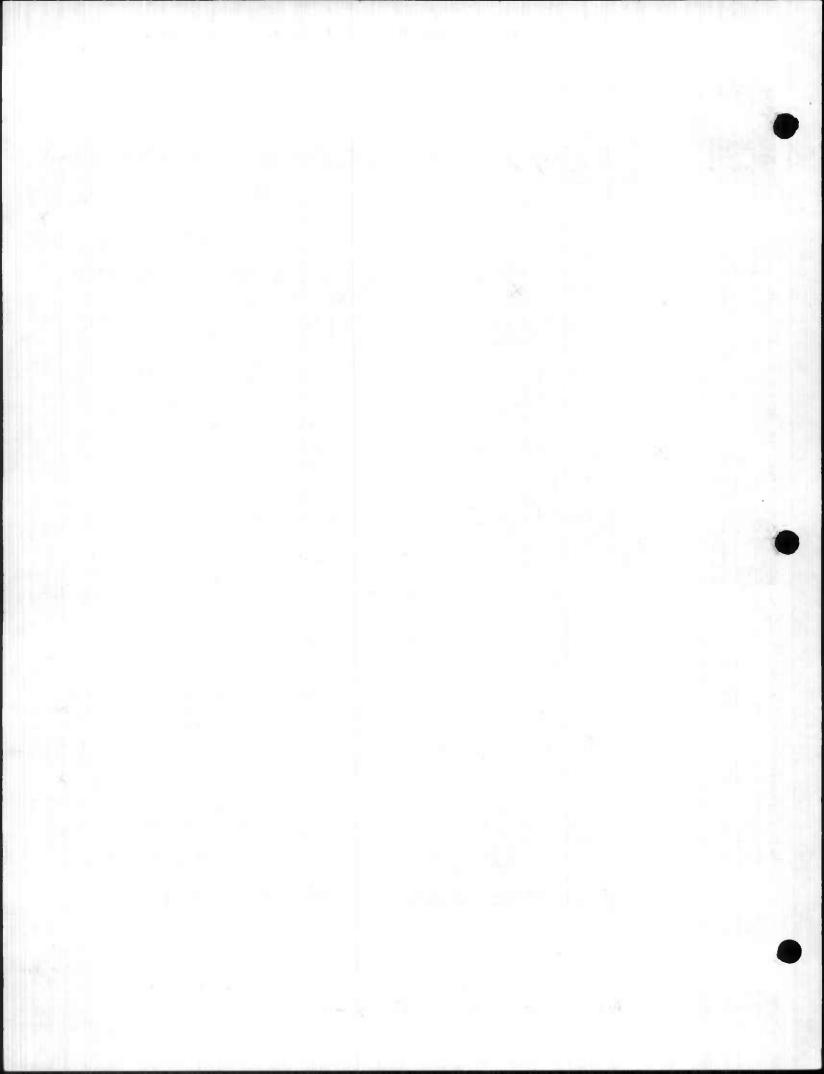
29b. Signeture end fitte of certifier

29c. License number 29d. Dete signed (Month, Dey, Year) August, 7, 1999

at 200 Memorial Avenue, Westminster, MD 21157 32. Registrer's Signature

Registrar

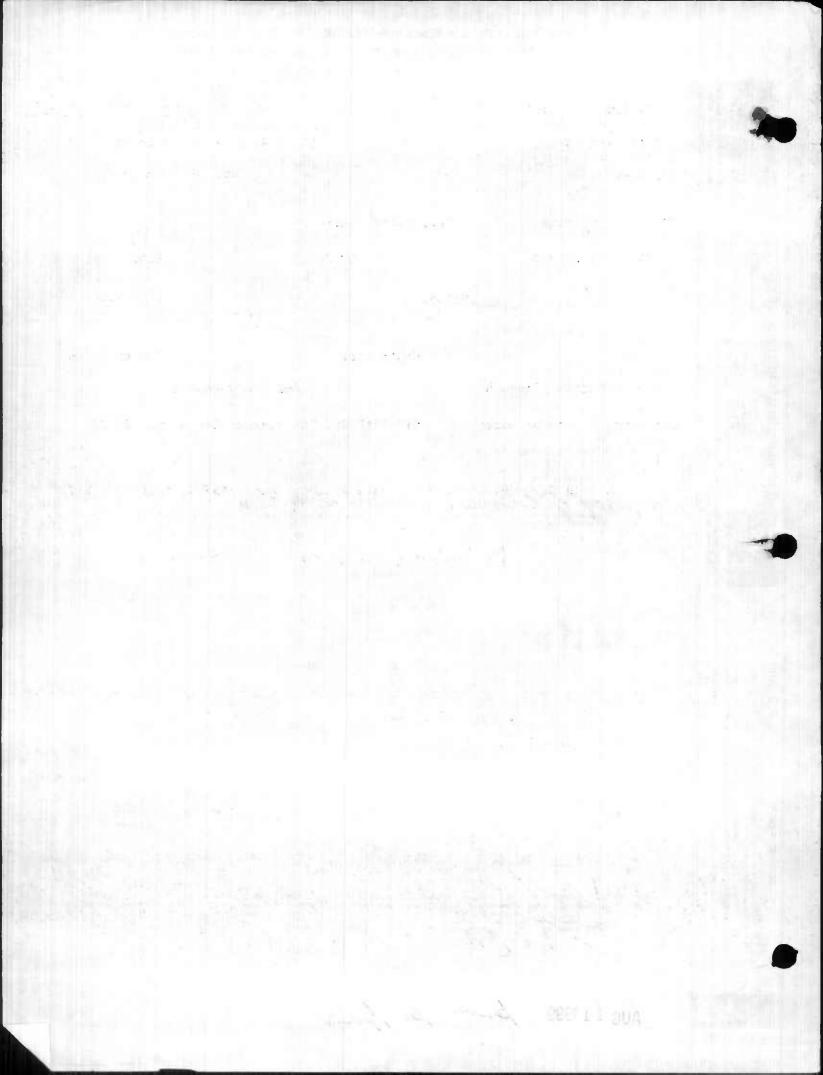
Medical



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State of Maryland / Department of Health and Mental Hygiene 9 9 25325

						(Certificat	e of	Death			Reg. No.	Con	.0020	
		1. Decedent'a Nan	ne (First, Middle, L	ast)							2. Date of Dea	ath Day	Year	3. Time of Death	
Physici /Medi		Willia	am J. Li	pscomb							OS.	O2	99	0847	
Exami				ive street and number	or)				4b. City, To	own, or Lo	cation of Death		of Death		
		3812	27th Stre	eet					Ches	apeal	ke Beac	h Calv	ert		
Funeral		5. Social Security I	Number 6.		Age (In yrs.	last birth	day) If Under	1 Year Days	If Under	24 Hrs.				place (State or Foreigntry)	
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anyla sho	5	1122												1 ☐ Yes 2X N	
No M	Director	MD Calvert Chesapeake Beach								10g. Citizen of What Country?					
Vith I	Dir	10e. Street and Number 10f. Zip Code												ntry?	
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er de	nu	11. Marital Status	Armed Forces	. Was Decedent Ever in U,S. Armed Forces?			cify Cub	an, Mexice	n, Puerto	ecify Yes or No- Rican, etc.) 14. Race - America Black, White, e					
13-0020 in 72 hours effer death with the Maryland n 72 hours effer 63th or 28a-f show added Examiner must be notified	by F	1 ☐ Never Man 3 ☐ Widowed	If Yes, Give Year or Dates	1 Types 2 No If Yes, Give 1955-59 Year or Dates:		.59 1□ Yes 2ᢂ No Specify:			:		Specif	y: White			
Maryland 21215-0020 2 should be filed within 72 hours of the and Mantel Hygiene. It is marked other than "neturel", or traumatic event, if a Maricel Exam	Completed	1000	15. Decedent's l	Education		16a F	Decedent's Usua	al Occup	pation	et of worki	ina	16b. Kind of B	usiness/In	dustry	
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be filed tel Hygid d other event, tr	Be (17. Father's Name	(First, Middle, Las	it)		_			18. Moth	er's Name	e (First, Middle,	Maiden Sumar	ne)		
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should I		19a. informant's N	lame/Reletionship	(Type, Print)		19b. l	Mailing Address	(Stree	t and Numb	er or Rura	al Route Numbe	er, City or Town	, State, Zip	Code)	
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of Hem		20a. Method of Dis	•			laca of [Disposition (Nat	ne of			Dete	20c. Location	- City or To	own, State	
			☐ Cremation 3 ☐ Other (Spec	☐ Removal from Stat ifv)	te	cemetery, crematory or other place)									
emit. Pag Separtment mportant: I my fojury o			werst Service Lice				22. Name ar	d Addr	ess of Facil	ity					
D Popular		No.	Ronald S	Warde, D	irect	or	State Baltin	Ana	tomy	Board	1, 655	W. Balt	imore	St.	
Physician		23a. Fart1. Enter lock, or hea	the disease, of col art failure. List onl	mplications that caus y one cause on each	ed the deat line.	h. Do no								Approximate Interval Between Onset and Death	
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nding use ex	Medicai	Cause (Diseese or that initieted event resulting in death)	IS T	c	Due to (or as a consequence of):										
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The law ate has	mc										10	Yes et No			
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i or Attending after death. Director: After d in by the fune	Ica	2 ☐ Accident 3 ☐ Suicide	6 Could not	be as also of	Inium - At he	ome farr	n, street, factor				28f. Location /	Street and Num	ber or Rur	ral Route Number,	
f or Attending after death. Director: Afte	in a	4 Homicide	determine	building,	etc. (Specif	y)	11, 311001, 140101	y, 011100			City or To	wn, State)			
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	aiC	29a. Certifier	1 Certifying F	hysician: To the bes	st of my kno	wledge,	deeth occurred	et the t	ime, dete e	nd plece,	and due to the	cause(s) and m	enner aa	stated.	
in 24 i	edicai	(Check only one)	2 ☐ Medicat Exa	miner: On the basis and manner	of examina	tion and/	or investigation	, In my	opinion, de	ath occurr	red at the time,	date and place,	and due t	to the cause(s)	
within 2 To the comple	ž	29b. Signature and	d title of centiles	1	7		29	c. Licen	se number			29d. Date signe	ed (Month,	, Day, Year)	
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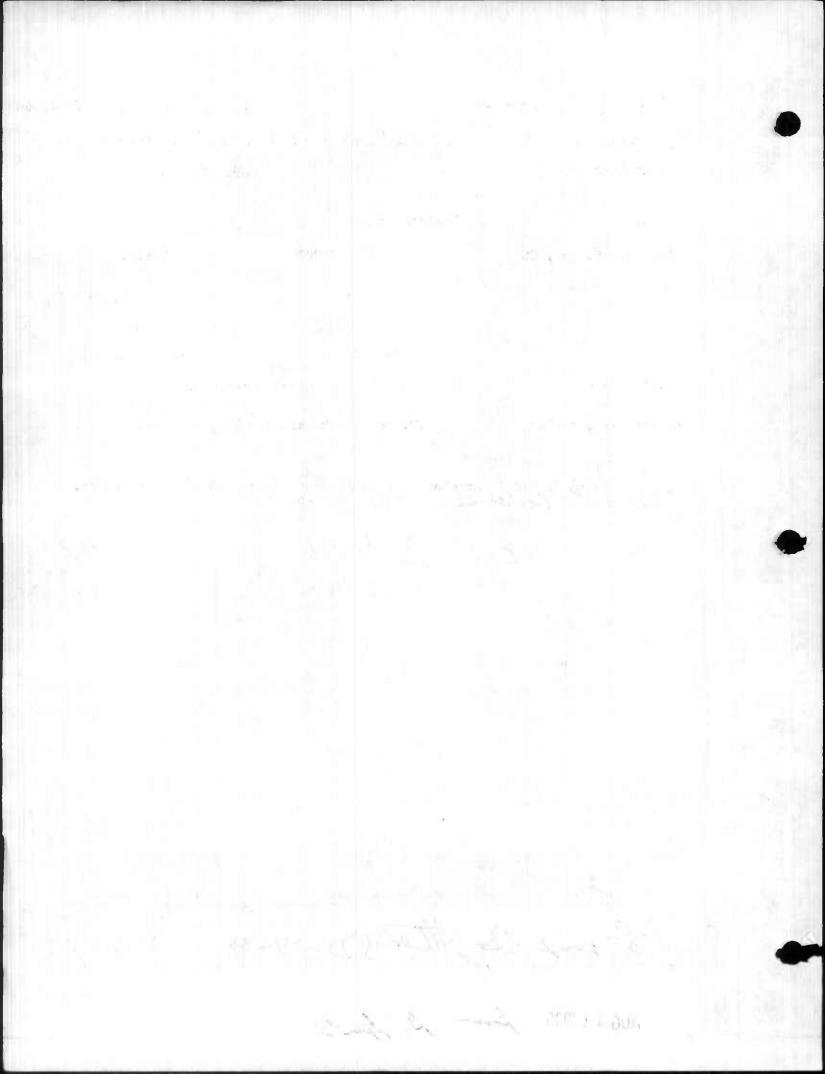


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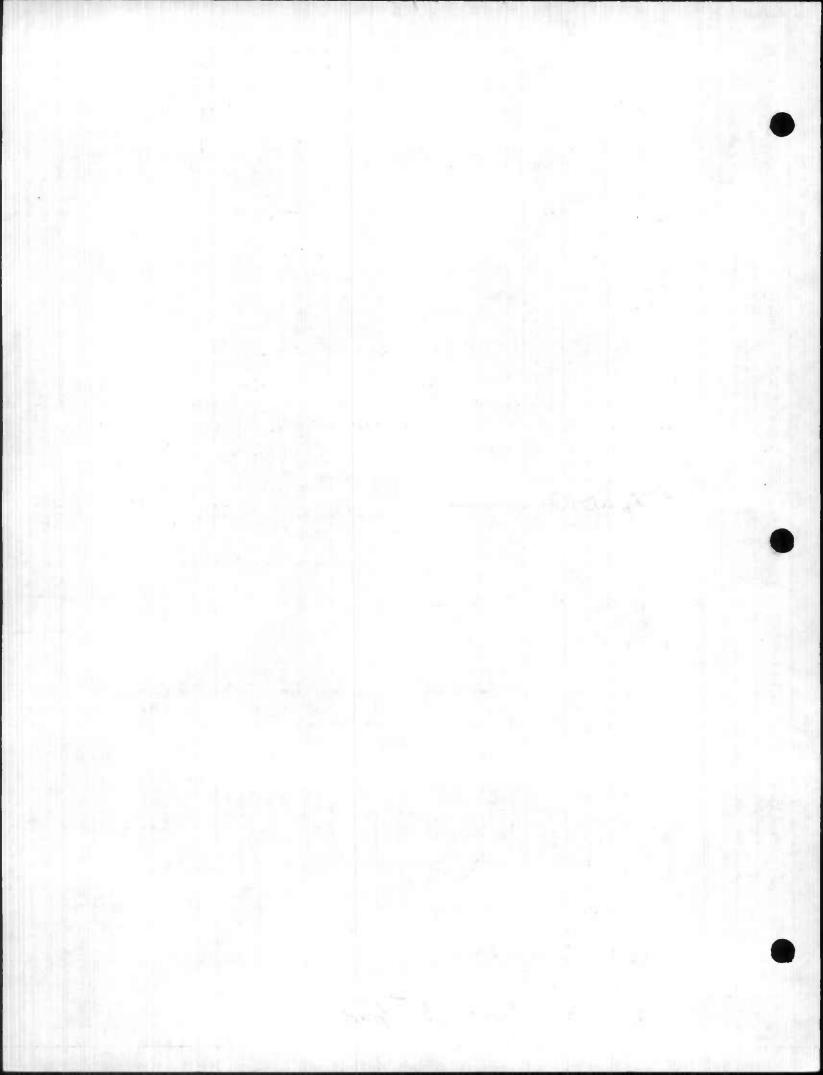
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Physician /Medical Examiner	DONALD Pecility Name (First, Middle, Letter DONALD) 4e Fecility Nama (II not Institution, girls)	L.		LEE	4b. City, Town, or Le	2. Data of Deat Month AUGUST ocation of Death	Day 6, 199 4c. County	9 4	:28P.M.	
Funeral Director		Sex 7. Aga (In yrs. 72)	last birthday) Yrs.	If Under 1 Yaar Months Days	RATITIMO If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Sept • 19	Year) 9,1926	9. Birthplaca Country) Mary 1	(Stata or Foreign Land	
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after death with the Maryland or Items 23e or 28e-f show refere mast be modified at Funeral Director	10e. Streel and Number 1813 E. North Av	e.		10f. Zip Coda	1	Og. Citizen of V	What Country?	es		
F. F.	11. Merital Stetus 1XXNever Marriad 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forcas? 12 Yes 2 □ No If Yas, Giva Year or Datas:		Vas Decedent of H Yas, specify Cub ☐ Yas 2 No	dispanto Origin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No- Rican, etc.)		a - Amarican Ir ck, Whita, atc.		
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De Control	17. Fathar's Nama (First, Middle, Last John		Lee		18. Mother's Nam Ozerbel	a (First, Middle, A			ris	
2 2 2 2	19e. Informant's Name/Ratationship	Type, Print)	19b. Meilin	g Address (Street	and Number or Rur	ural Routa Number, City or Town, State, Zip Code)				
Dalumore, nothing to the party of Health Important; if New 27 any Injury or other trains.	Erda Dabney / Si 20a. Mathod of Disposition 1 □ Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Speci	Ramoval from Stata	Placa of Dispos cematary, cran	Pall Ma sition (Nama of natory or other pla nt Crema			20c. Location -	21215 City or Town, M		
at the death certificate be executed by the attending physician and etached for use as the burial-transit by sician/Medical Examiner	23a. Part1. Enfer the disease, or comshock, or heart failure. List only Immediate Causa (Finel disease or condition rasulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that infiltated events rasulting in death) Last	a. Due to (c	h. Do not anter	uence of):	n Pasture ng, such as cardiac	or raspiratory arra	ras Cul	Apr Inte Ons	21286 convinata prival Between set and Death	
hat the detache	Part II. Other significant conditions of	ontributing to death but not ras	ulting In tha un	darlying causa giv	ven in Part I.		es 2 No		cause of death	
requires been sign should be						24a. Was a perform	n autopsy ned?	availab	autopsy findings le prior to ation of causa h?	
F Sa O						10/Ye	s 2 No	1 🛭 Ya	8 2 No	
Physician: The this certificate ral director, page Co	25. Was casa ralarred to medical examinar?	Hospital:	ER/Outpatien	3□ DOA Ott	26. Place of Deet	h <i>(Check only on</i> oma 5 ☑ Raside		or (Engelly)		
Lat or Attending Physical Control of State of St	27. Menner of Death 1 Natural 5 Panding 2 Accident investigatio 3 Suicide 6 Could not b	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	M 1 □		28d. Describe ho	ow Injury occur	red	uta Number,	
To the Hospital or within 24 hours after To the Funeral Dire completely filled in the Medical Certi	29a. Certifier 1 Certifying Pr	building, atc. (Specification) yalclan: To the best of my knoniner: On the basis of examine	wledge, deeth	occurred at tha tir			ause(s) and ma			
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State Registrar	31. Data filed (Month, Day, Year) AUG 1 2 1999	complated cause of deeth (Iten	iture 1		Street, E	Baltimore	e, Mary	land 21	L 201	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#26 PER VERBAL RESPONSE G774 8-12-99 J.A 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Deeth **Physician** John Locust, Jr. July 30, 1999 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 3907 Eldorado Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Soclei Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours M 2DF Months 212-22-7477 Yrs. Director Sept. 20, 1927 Va. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. n/a Baltimore 1XXXes 2∏No Director must be notifie 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21215 3907 Eldorado Avenue USA Funeral Merre Raca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status Pages 1 and 2 should be filed within 72 hours after earl of Health and Mental Hydjeno.

ant if item 27 is marked other than "natural", or ite arry or other traumalic event, its Medical Examinatory or other traumalic event, its Medical Examinate. No Yes 2 No MY Yes, Give 1 Never Married 25 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Steel Worker Bethlehem Steel 12th Grade altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John R. Locust, Sr. Helen King 19a. Informent's Neme/Reletionship (Type. Print) wife 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy V. Locust 3907 Eldorado Avenue Baltimore, Md. 21215 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify) Department of Important: If any injury or Garrison Forrest Veterans Aug. 6 Owings Mills, Md. 21, Signeture of Funerel Service Licensee 22. Name end Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete tnterval Between Onset end Death Physician /Medical Immediate Cause (Final DOWCHLOG EWIC disease or condition resulting in death) Examiner Examiner MARY LM M MANZY The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and Due to (or es a consequence of) P.O. Box 68760 Physician/Medical the Due to (or es a consequenca of): USB &S Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown bengis Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? page 2 1 ☐ Yes 2 No 1 Yes 2 No certificate or Attending Physician: funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? After 5 Panding investigation NIA NIA 1 ☐ Yes within 24 hours after death. To the Funeral Director: A NIA 2 Accident 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide N Hospital 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier completely (Check only one) å 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Dey, Year)

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30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

32: Registrer's Signeture B. Sparle

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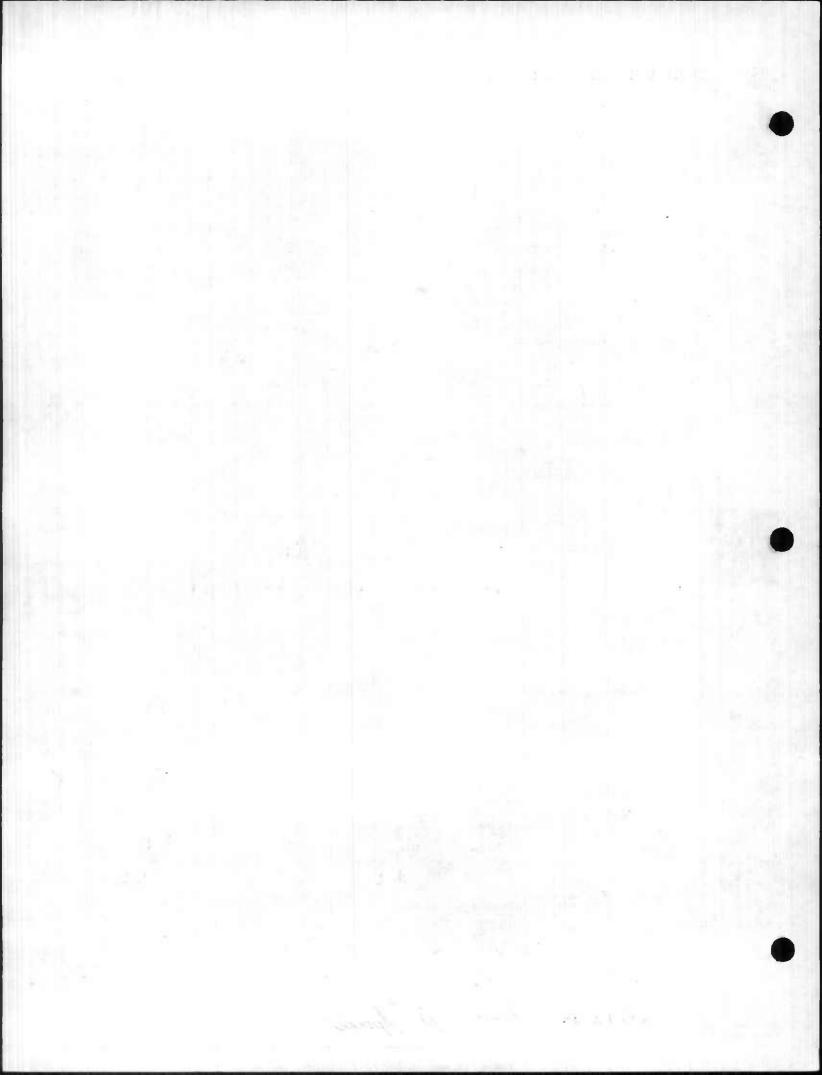
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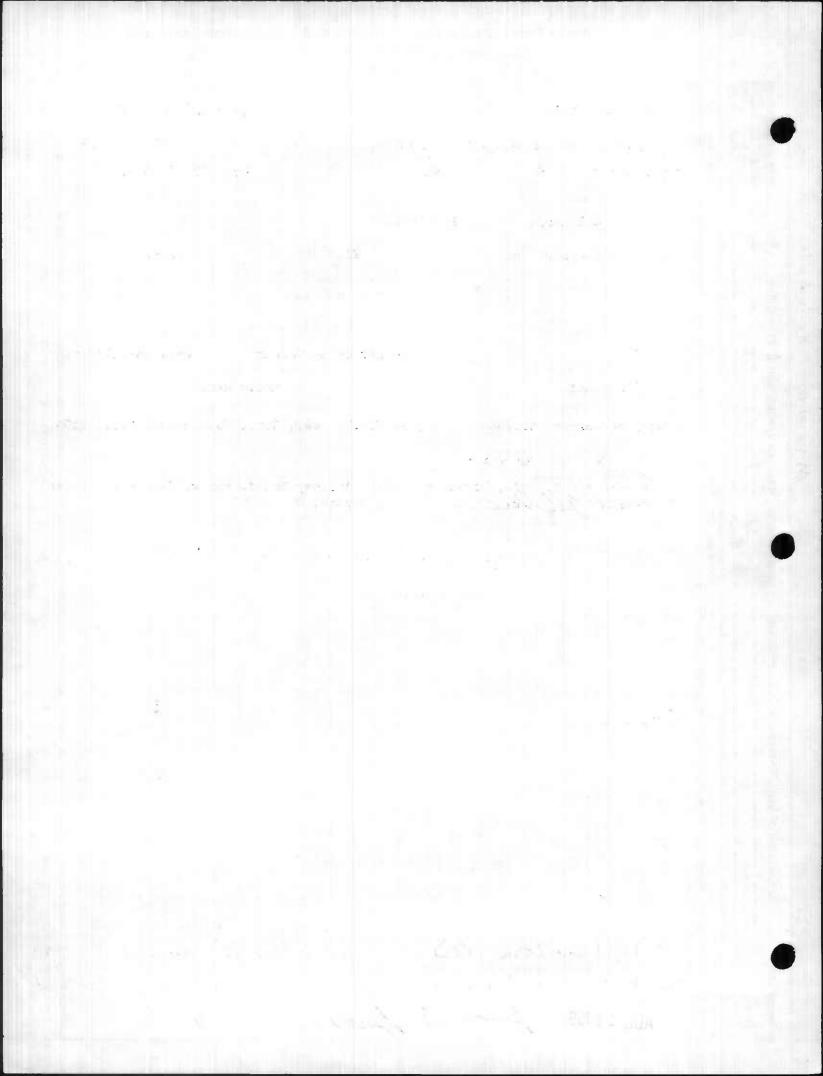
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name /First, Middle, Last) 2. Date of Death 1999 5:30 P.MI Marvin Mitchell August 4b. City, Town, or Location Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Rosedale BAITIMORE SEUARE HOSPITAL Cen Tek FRANKlin If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) D. C. Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1⊠M 2□ F Months Days 62 577-48-8658 Usual Residence of Deceden 10c. City, Town or Location 10a State 10b County 10d. tnside City Limits 1 ☐ Yes 2 No MD Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1300 Windlass Drive 21220 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Residential/Commercial Construction Worker 18 Mother's Name (First Middle Maiden Surpame) 17. Father's Name (First, Middle, Last) Carl Mitchell Macie Hines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intormant's Name/Relationship (Type, Print) Samuel McPherson, Sr./son 3214 M.L.K. Ave., S.E., Washington, D.C. 20032 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetion 5 🗴 Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, Director State Anatomy Board, 655 w.

Baltimore, MD 21201

23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. 22. Name and Address of Facility
State Anatomy Board, 655 w. Baltimore Street Approximate Interval Between Onset and Deeth Immediate Cause (Final a. Hepatic Encephalopathy
Due to (or as a consequence ot): Iweek disease or condition resulting in death) Examiner Liver FAILURE Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sepsis 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Mapner of Death Dete of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Seletural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Certifying Phystcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medicat Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier To the To the To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Chardon 9000 FRANKlin Square DR. BAITIMORE, MARYland MADAi 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State AUG 1 1 1999 Registra

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Day Thomas D. Maloney, Jr. July 31, 1999 1:25pm 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death CIVISTA MEDICAL CENTER LAPLATA CHARLES 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1X M 2□ F Months Deys Hours Min Yrs. 63 Jan. 6, 1936 220-32-6386 D.C. Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD Charles Bryantown 10e Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 13988 Huckleberry Ct. 20617 U.S.A. 14. Rece - American Indien, Black, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 President/Owner School Bus Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Dennie Maloney, Sr. Marjorie Mae Farrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Ann Maloney/daughter 13988 Huckleberry Ct., Bryantown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service License 22. Name and Address of Facility Ronald S. Wade, Director State Anatomy Board, 655 W. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heard feilure. List only one cause on each line. State Anatomy Board, 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) 00 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 2 any higher or other traumatic svent, the Medical Examiner must be an once.

altimore, Maryland 21215-0020

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Examiner Physician/Medical 2 950 2 Completed

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Division

To the To To the I State Registrar

31. Date tiled (Month, Day, Year) AUG 1 1999

29b. Signeture end title of certifier

25. Was case referred to medical examiner?

5 Pending Investigation

6 Could not be determined

1 Yes 2 No

27. Menner of Death

1 Natural

2 Accident

3 Sulcide

(Check only one)

29e. Certifier

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

1 Yes 2 No

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 29d. Date signed (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Plece of Deeth (Check only one)

D-46046

Amir A. Mirza Alikhani, M.D. 118 LaGrange Ave. PO Box 1890 LaPlata, MD 20646

32 Registrer's Signeture

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Misselb **Physician** Naomi Mallon ugus 3:00 AN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De Examiner Saluare 12 21215-0020 MOM; Helen Baltimore Hosbita Kosedale enter If Under 24 Hrs. 7. Age (In yrs. last birthday)
76 Yrs. If Under Months 8. Dete of Birth (Month, Day, Year) 5-6-23 6. Sex Birthplace (State or Foreign Country) Social Security Number 216–18–6419 **Funeral** Days Min. 1 M 2 XF Director MÓ **Uauaf Residence of Decedent** 10a. State 10b. County Baltimore 10c. City, Town or Location ESSEX 10d. Inside City Limits 1 Yes 2 No Funeral Director 28a-f 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? ò 1000 Franklin Ave. Apt. 316 21221 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried b 1 Yes 2 No Specify: Specify: white À 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) Phillip Meagher Sr. 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nemed of Mental 1 Lillian Smith 19a. Informant's Name/Reletionship (Type, Print)
Paul Mallon / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Fox Bow Dr. Bel Air, MD 21014 Health (20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore National 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 8-12-99 Department of important: If eny legary or price. Catonsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
CVach/Rosedale Funeral Home 21. Signature of Funerel Service Licenses 1211 Chesaco Ave. Rosedale, MD 21237 Misc 23a. Part1. Enter the disease, or complications that caused the cleath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Week Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the deeth certificate be executed use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): P.0. Part ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ver 1 Yea 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: funeral director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Jaunpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Neturel 2 Accident 5 Pending investigation I after death.
I Director: Aff 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funerel D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stafed. 29e. Certifier 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) mda MD

State Registrar **DHMH 16 Ray 6/95**

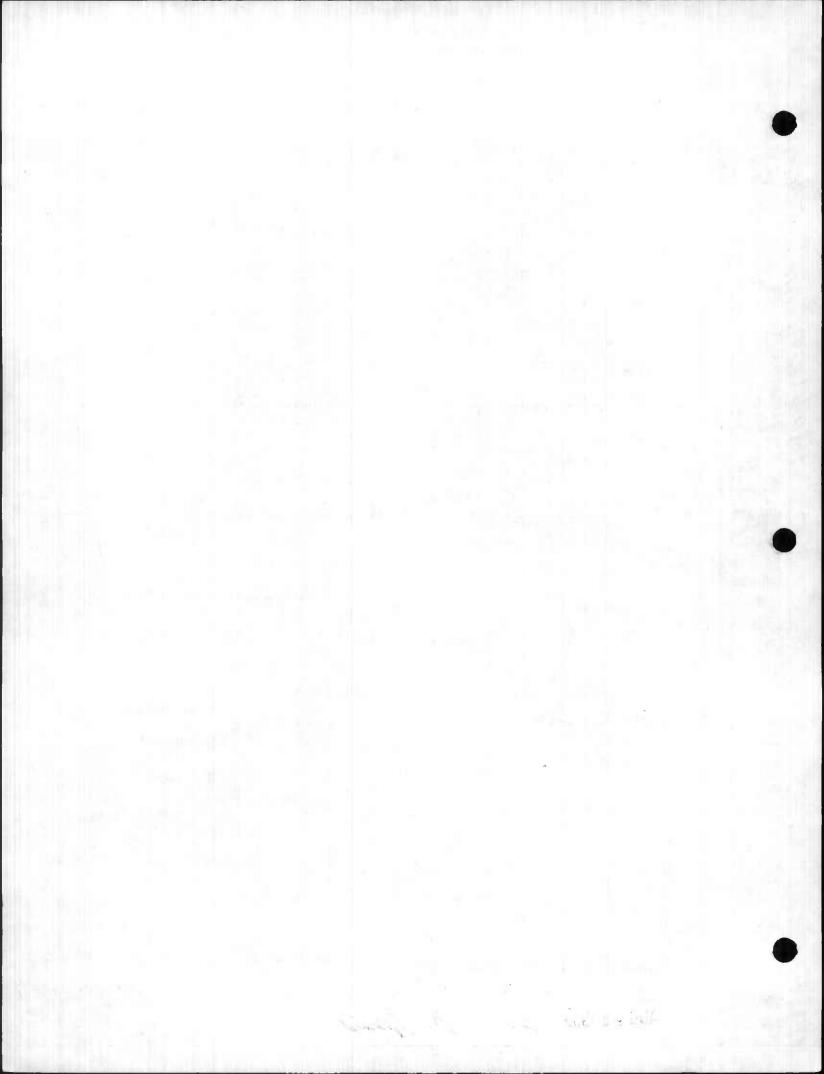
AUG 1 2 1999

31. Date filed (Month, Day, Year)

Dr Savitha Shivananda 9000 Franklin Square Drive Baltimore, Maryland 21237 32. Regi

iss of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL



Piesse Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. AMEND 318#26 PER MD. G774 8-12-99 J.A 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** WILLIAM Suly 2 1999 12.m. 5 /Medical 4a Facility Nama (II not Institution give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) N/A Johns 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 180 M 2 F 203-07-4763 84 05/15/1915 Director Scotia, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show notified at 1 ☐ Yes 2 No Director Pa Montgomery Jenkintown 8 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b the Medical Examiner must be 768 Crosswicks "natural", or flams 23s Road 19046 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yas, Giva Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specity: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Owner 12 Allied Concrete 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 52 should be fit h and Mental H is marked off Vivian Murwin Frances Frost 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is n 521 Cedar Hill Road Ambler, Pa 19002 William J. Murwin, Jr/son 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata ò St. John Neumann Cem 7/29 Chalfont, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licenses 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home Marsh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21228 Approximate Interval Between Onset and Death **Physician** 20 Immediate Causa (Final disease or condition resulting in death) /Medical Minutes VENTRICULAR Examiner Dua to (or as a consequence of): Examiner Cardiovascular YOARS hroschnotic nding physician and use as the bunal-transit certificate be executed Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Operular ereboral Accident Physician/Medical Dua to (or as a consequence of): 98 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings Completed 24a. Was an autopsy performed? available prior to completion of cause of death? Tha lew cartificate has paga 20 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence (Specify) 1 Yes 2 No To 2 ER/Outpetient 30 DOA this Aftar this 27. Menner of Death To the Hospital or Attending Privithin 24 hours after death.
To the Funeral Director: After the complately filled in by the funera 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending invastigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Box 68760. P.O. Records. Division of Vital

Saltimore, Maryland 21215-0020

D3546B WS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIANG, MD TURRECE

State Registrar 31. Data filed (Month, Day, Year) AUG 12 1999

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

25

2000, 812VA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** KOBERT 21510626 3:04AM /Medical 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number INORIA! HOSPIT av) If Under OAKLAND If Under 24 Hrs. 8. Det IDE 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 18 M 2□ F Months Hours Usual Residence of Deceden Director 28P1 18XA 10a. Slela 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 1 ☐ Yes 2 No Director MARFORD MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23e 21050 .0 1408 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or from any Injury or other traumatic avant, the Medical Experiments. Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: \ 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 28 No Specify. p 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SCHOOL BOARDOF College (1-4or 5+) Elementary/Secondary (0-12) 12485 6YRS BALLINDRE 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Ednizi GRAY HEARY ARGARET 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Raletionship (Type, Print) KAHO MARYLAND AMLZH 1521 510621 Pub 13 20b. Place of Disposition (Name of cemetery, cremetory, or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel Irom Stete 1990 4 □ Qonation 5 □ Other (Specify) FARKWOOD LENELER 21. Signature of Euneral Service Licensee 22. Neme end Address of Fecility G. A CHAPIL- BILA'IR 3 NEW PORT DI EVANS 31050 DRIVE FORUST ORAL VSA 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Deeth **Physician** /Medical mmedieta Causa (Finel 2 Days disease or condition resulting In death) hemotherapy In

Dua to (or as a consequence of): perch Tropress Examiner Examiner 5 MHbs that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the bunal-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? Yes 2 No 3 Probably 4 Unknown Artery Disease With Bypas, Emphysem signed b Records, Completed by 24b. Wera autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Abdominal Aport, e Anerger, Arthritis 28 No 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only ona) Hospitel: Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Neturel 5 Pending Apital or.
A hours after des.
Arai Director: A'
'y by the 1 ☐ Yes 2 ☐ No investigetion 2 ☐ Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, 1erm, street, lectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft. To the Funeral Diccompletely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the causa(s) and mennar as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of pertifier 29c. License number 29d. Dete signed (Month, Day, Year) JPPZC 30. Name and address of person eted cause of death (ttem 23a) (Type, Print) Me raiser Highway 31. Dete filed (Month, Day, Year) THONE 32. Registrar's Signeture State Registrar DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath Day Month AUSTIN **EMERSON** PENN 10, 1999 10:20AM August 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore Months Days Hours Min. 0ctober 12, 1904 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) XXX 20F Yrs 94 212-05-6619 Maryland Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1□ Yes XXX Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 USA 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Raca - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas XXXVo If Yas, Give Year or Dates: 1 ☐ Yes X X X Yo X XVidowed 4 Divorcad Specify. White 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Executive Utilities 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) S Penn Elmer Louise Lightfoot Mary 19a. Informant's Name/Relaflonship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Richard E. Penn 20715 Keeney Mill Road Freeland, Maryland 21053 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Bunial 2 Ocremation 3 Removal from State 4 Donation 5 Other (Specify) 8/12/99 Baltimore, Maryland Greenmount Cemetery 21. Signature of Funeral Service Li 22. Name and Addrass of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 nny 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Immediate Cause (Final Heard Failing disaase or condition rasulting in death) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior fo complation of cause of death? 24a. Was an autopsy performed? 1 ☐ Yea ♣☐ No 1 □ Yas 2 □ No 25. Was casa referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of fnjury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 A Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 28e. Placa of Injury - At home, farm, streef, factory, offica building, etc. (Specify) 3 Suicida 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 Homicide

or Attending Physician: The law requires that the deeth certificate be executed Box 68760. P.O. Records, of Vital Division

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland neart of health and Mental hyglene. Intit if team 27 is marked other than "neturel", or items 23a or 28a-f show ury or other traumatic swent, the Mencal Examiner maint be notified at

permit. Peges 1 and 2 should be filed will Department of Health and Mental Hyglan Important: If item 27 is marked other the any injury or other traumstic svent, its page.

Physician /Medical

Examiner

the buriel-transit

Physician/Medical Examiner

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

certificate

this

After

within 24 hours efter deat To the Funeral Director:

funeral director,

Baltimore, Maryland 21215-0020

State Registrar

Andrew 31. Date filed (Month, Dey, Year)

29b. Signature and title of certific

32. Registrar's Signatura

711

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

(421.5

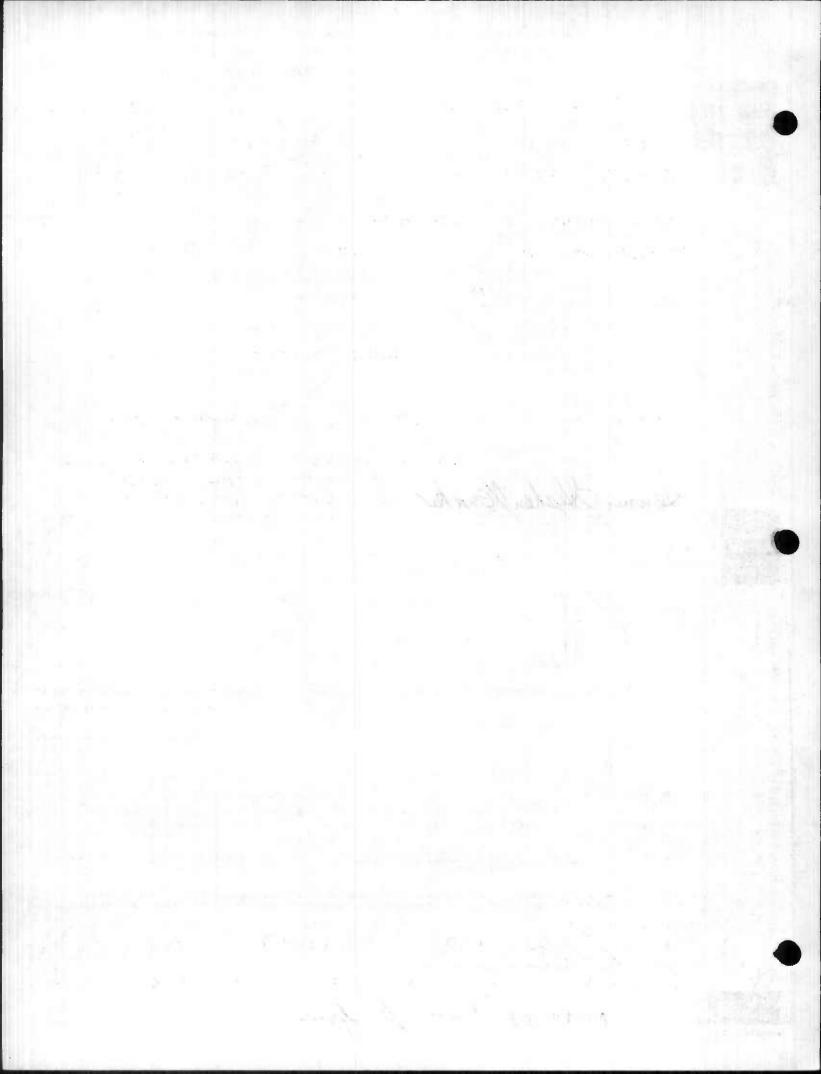
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Lane

Maide choice.

160 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

(atunsville



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month NORMAN 1999 PETERSEI 1:10 Am AUP 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth AGNES BALTIMORE HOSPITAL TIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Mours Min. (Montly, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) Months -09-0868 Yrs. **Usual Residence of Decedent** 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMURE CATONSVILLE 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 USA CHARLESTOWN CARE CENTER 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: CAUC 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Engineer Grand Union Co. 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Fredrika Frederickson Peter Petersen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 2 8 19a, Informant's Name/Relationship (Type, Print) 715 Maiden Choice Lane Catonsville, Md. Ruth Petersen/Wife 20b. Plece of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Steta Baltimore/Washington 8/10 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling=Ashton-Schwab 21. Signature of Funeral Service License an 736 Edmondson Ave. Catonsville, Md.21228 Part 1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shows a heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Heart failure Immediate Cause (Final disease or condition resulting in death) Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interests) Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Exampler must be notified at

"natural", or

filed within 7 Hyglene.

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Nem 27 Is marked oths eny Injury or other treumatic event, bibbs.

5

Baitimore, Maryland 21215-0020

Director

Funeral

P

Completed

Physician/Medical Examiner þ Be Completed

page 2 should b After this certificate deeth. Director:

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27. Manner of De

To the Hospital within 24 hours e To the Funeral Completely filled D

8

of Vital Records,

NORBAN

Natural

3 ☐ Suicide

29a. Certifier (Check only one)

2 Accident

4 Homicide

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifier

MD

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number 46704

1 Yes 2 No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

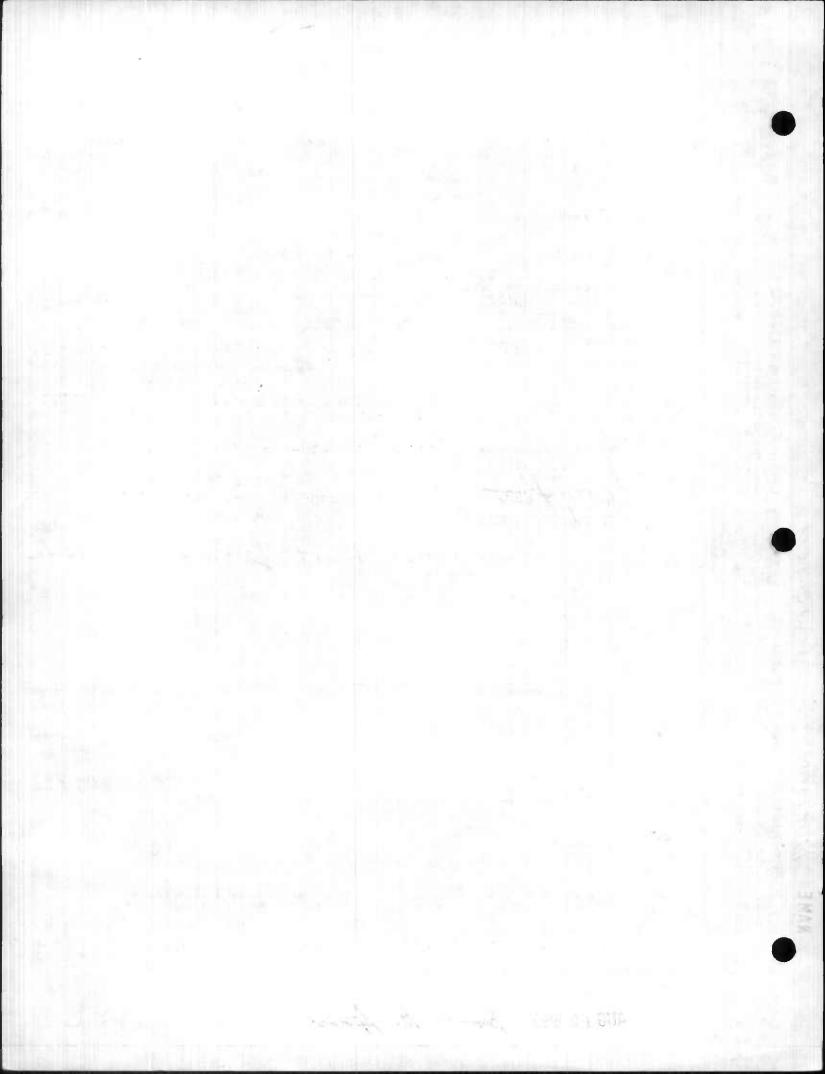
DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

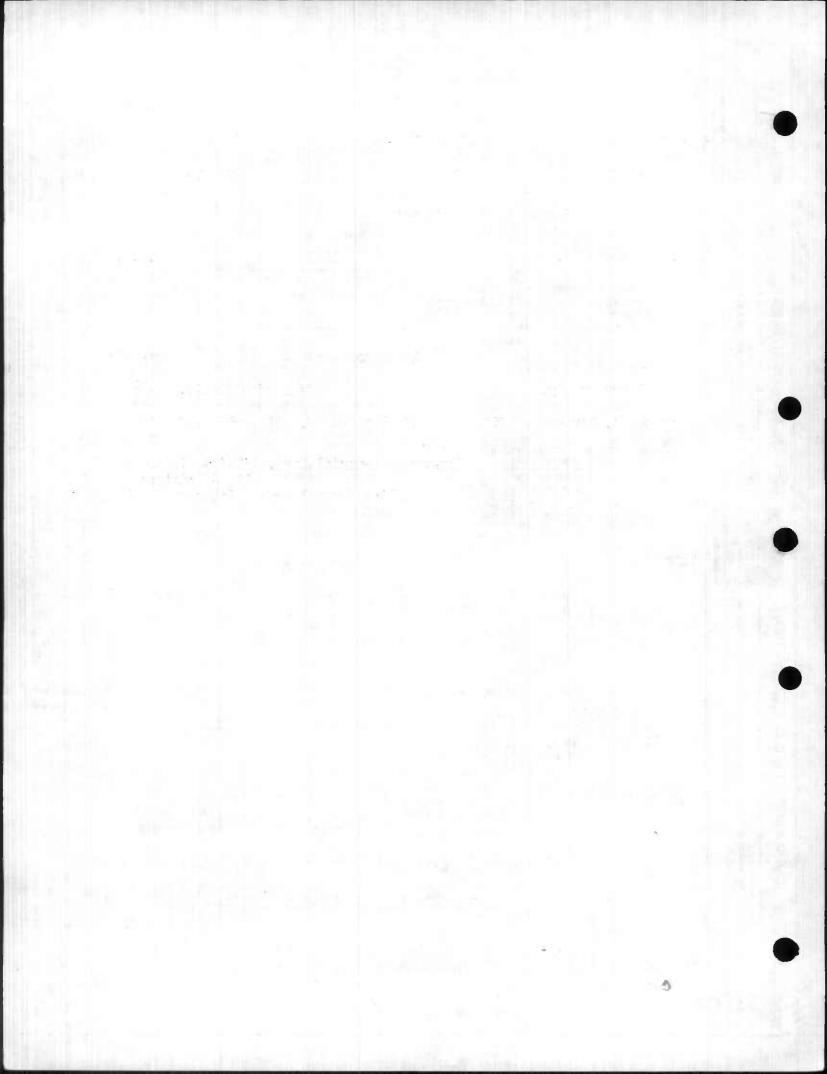
5 Pending investigation

6 ☐ Could not be



hysician	1. Decedent'a Name (First, Middle, Las	it)	-				2. Date of De		м.	3. Time of Death		
	N	LELV	1115	P	ONTE	77		Augu	Day (1)	Year	720		
Medical xaminer	4a Facility Name (If no			(r)	7,000		4b. City, Town, or i	F / F - W		of Death	DM		
Callinet	Nonth		GESTAL	_ Q=	NTER		PANDAL	(CTANA)	-	Time	n=		
ral	5. Social Security Num	ber 6. Se	9x 7./	Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da			ce (State or Foreign		
tor	216-24-695 Usual Residence of De	1	DM 2DF	70	Yrs.	Months Days	Hours Min.	March 1		Country	MD		
		0b. County		10c. Cit	y, Town or Loc	ation				100	I. Inside City Limits		
23s or 23s-f sho at be notified at al Director	MD	Baltimo	re	P	ikesvil	le					1 ☐ Yes 2 No		
Director	10e. Street and Number	9r				10f. Zip Code			10g. Citizen of W	Vhat Country	n		
- E	932 01mst	ead Rd.				212	208		U.S	. A.			
Funeral	11. Marital Statua		12. Was Deceder Armed Forces	t Ever in U	,S. 13. W			pecify Yes or No		14. Race - American Indian,			
by Fu	1 Never Married 3 Widowed 4				11	□ Yes 2 No	Decedent of Hispanic Origin? (Specify Yes or , specify Cuban, Mexican, Puerto Rican, etc.) (es 2 No Specify:			k, White, etc. White	hite		
	15	. Decedent's Ed	ucation	cation 16a.		ent's Usual Occu		16b. Kind of Bu	isiness/Indu	stry			
Completed	(Specify Elementary/Seconds	only highest grad	le completed) College (1-4or 5+)		(Give kind of work done during most of work life. DO NOT use retired)			SKIIIG					
E O	12	dary (0°12) Conege		. 54)	Rout	e Manage	er		Coca-Cola				
Be	17. Father's Name (Fir	st, Middle, Last)							irst, Middle, Maiden Sumame)				
0	Lemuel Porter, Sr. Catherine Stockman												
	19a. Informant's Name	e/Relationship (7	ype, Print)		19b. Mailing	Address (Street	t and Number or Ru			State, Zip C	ode)		
	Dorothy A	. Porter	Wife	_			Rd., Pik	esville,	MD 212	08			
	20a. Method of Dispos		Removal from Stal	-	lace of Disposi emetery, cremi	ition (Name of atory or other pla	ice)	Date	20c. Location -	City or Town	n, State		
	4 □ Donation 5				erareen	Memoria	1 Gard.	8/13/99	Finkshu	ra. Mi)		
d	21. Signature of Funer	ral Servicer Licens	100	0	22.	Name and Addre	ess of Facility		Reisters				
8	Eline Funeral Home Reisterstown, M										1136		
	23a. Part1. Enter the	disease, or comp	lications that cause one cause on each	ed the deat						. A	pproximate		
0	Jook, or ribarri		Interval Between Onset and Death										
al	Immediate Cause (Fin disease or condition	al		SEPSIS FEW DAY									
er.	Due to (or as a consequence of):								1	1/2			
in or													
Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury C.												
	cause. Enter Underlyi	ediate ng											
odical	that initiated events resulting in death) Las		C	Due to (or as a consequence of):									
- 4			al.										
S S			d							1			
by Physician/M	Part II. Other significa	nt conditions co	ntributing to death	but not resu	ulting In the und	derlying cause gi	ven in Part I.	23b. Dld 1	tobacco use con	ntributa to ti	he cause of death		
4	PANC	400	ENIA					10	Yss 2 No	3 Probe	bly 4 thinknow		
by	P	1								0.45 144	a a da a a a dia dia a a		
ete	KENA	L CA	- W17	4	ME7	ASTACO			an sutopsy med?	avail	autopsy tindings able prior to pletion of cause		
										of de	ath?		
윤								101	Yes 2 No	10	Yas 2000		
Comp			Hoopital:			l ou		ith (Check only o	one)				
_ m	25. Was case referred examiner?		Hospital:		ER/Outpatient	3LI DOA			dence 6 Othe				
٩	examiner? 1 ☐ Yes 2 ☐ Nor			iury ev Veerl	28b. Time of Injury	28c. tnju Wo		28d. Describe I	how injury occurr	ed			
2	examiner? 1 Yes 2 Death 27. Manner of Death	5 ☐ Pending	28a. Date of In (Month, D	ay rour/	M 1 Yes 2 No								
2	examiner? 1 Yes 2 Deep 27. Manner of Death 1 Dividural 2 Accident	5 ☐ Pending investigation	(Month, E					0011		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
٩	examiner? 1 Yes 2 Deep 27. Manner of Death 1 Dividural 2 Accident	5 ☐ Pending	(Month, D		ome, farm, stree	et, factory, office				er or Rural F	Route Number,		
Certification: To	examiner? 27. Manner of Death 1 Driver 5 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	28e. Place of Inbuilding, 6	njury - At ho	v)	et, factory, office		City or Tox	vn, State)				
al Certification: To	examiner? 27. Manner of Death 1 Evidatural 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only 2	Dending investigation investig	28e. Place of libuilding, discian: To the besiner: On the basis	njury - At ho etc. (Specify t of my know of examinat	v) wledge, death o	et, factory, office		City or Tov	vn, State) cause(s) and ma	nner as stat	ed.		
edical Certification: To	examiner? 27. Manner of Death 1 Dividatural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	Denting investigation Could not be determined Certifying Phy Medical Exami	28e. Place of Inbuilding, of	njury - At ho etc. (Specify t of my know of examinat	v) wledge, death o	et, factory, office	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as stat and due to th	ed. ha cause(s)		
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Medical Certification: To	27. Manner of Death 1 Evidatural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title	Dending investigation Could not be determined Certifying Phy Medical Exami	28e. Place of Inbuilding, of the basis and manner s	njury - At ho otc. (Specify t of my know of examinal stated.	wledge, death of investigation and/or investigation	et, factory, office occurred at the ti stigation, in my of	me, date and place opinion, death occu se number	City or Tow , and due to the rred at the time,	cause(s) and ma date and place, a 29d. Date signed	nner as stat and due to the	ed. ha cause(s)		
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State Registrar 0

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31. Date file

Month, Day

Year)

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111 Penn Street, Baltimore, Maryland 21201

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32. Registrar's Signature

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THE COTIONS & OUGARDITIES TO PRICATE HITTERSEE OF THE TENT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Seiser Illam dupm /Medical 4b. City, Town, or Location of eeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner ltimor Maris IMONIUM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey 9. Birthplaca (Stete or Foreign Country) Makyland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 76 Months Min 219-18-Days Hours 10 M 20 F 6338 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 le marked other than "naturel", or flema 23a or 28a-f ahow treumatic event, me Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3023 21234 Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Arroed Forces? 1 16 Yes 2 ☐ No If Yes, Give 11. Marifal Stetus permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene. Intercent: If flem 27 is marked other than "naturel", or ther any injury or other treumatic event. 1 Never Merried 2 Merried Specity: White 1□ Yes 2XNo Baltimore, Maryland 21215-0020 Specify. þ 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middles Malden Sumeme. Be O.L 19a. Informant's Name/Pelationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daught 2Qc. Location - City or Town, State 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other pleca) 1 Burlal 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Facility 23 Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting In death) Examiner Due to (or as a consequence of) Physiclan/Medical Examiner seme attanding physician and for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760 Due to (or as e consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No by 24b. Were autopsy findings evailable prior to 24a. Wes en autopsy performed? Completed completion of cause of death? pege 2 s certificate has 20No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending 5 Pending Investigation death. 1 Yes 2 No 2 Accident efter death 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours 29a. Certifie t Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, and due to the cause(s) end manner es steted. Medical compiataly 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the fime, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Enlaw of Inte Am MD 31. Date filed (Month, Day, Year) 32. Registrer's Signature

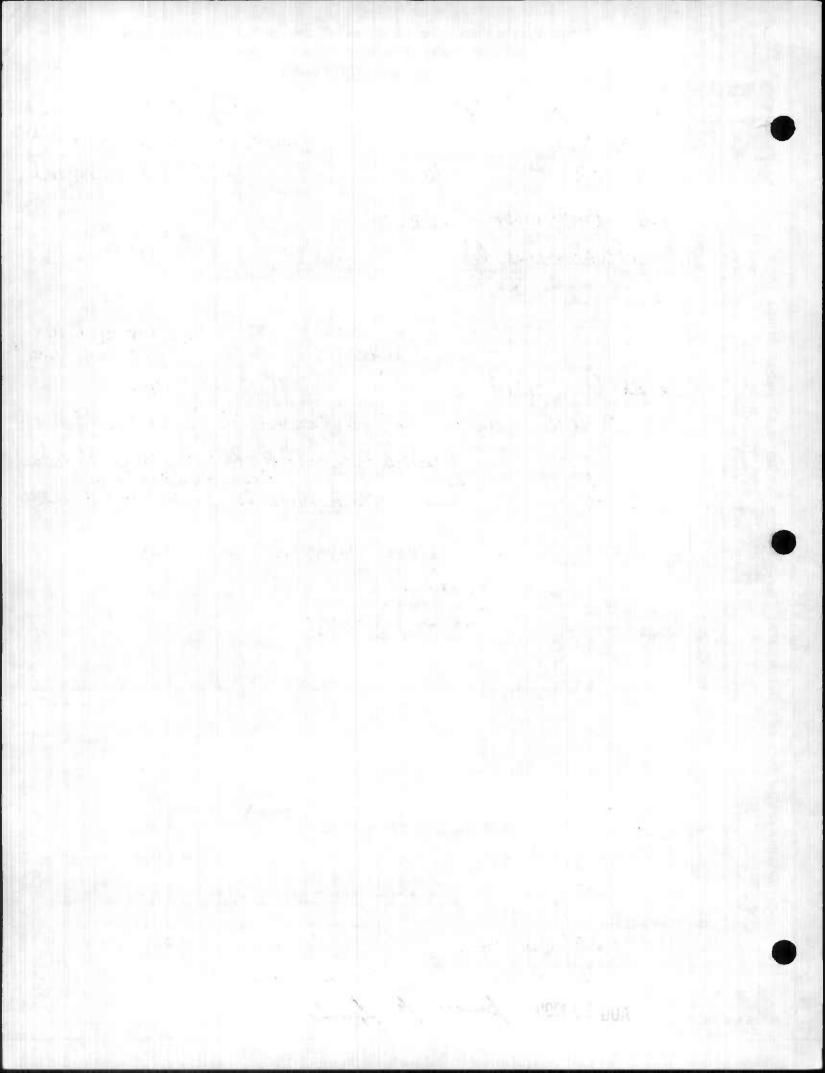
DHMH 16 Rev 6/95

State

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death 1:10 A.M. Irvin E. Smith Sr. August City, Town,

Perry Hall

If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

noc. 30, 1 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 9110 Santa Rita Road Baltimore If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Days Months 10 M 2□ F 63 Yrs 219-32-6819 1935 Maryland Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Baltimore Perry Hall 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21236 U.S.A. 9110 Santa Rita Road 12. Was Decedent Ever In U,S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Transit Company Driver 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Dorothy Phoebus Elmer Smith 19a. Informant'a Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 9110 Santa Rita Road, Perry Hall, MD 21236 Cecilia M. Smith (wife) 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State Gardens of Faith Maus. 8/14/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name and Address of Facility Schimunek Funeral Home Inc. Bi 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG CANCER 5 MONTA disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes SE No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes SKI No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 28e. Date of Injury (Month, Dey Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)

requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, or Attending Physician: death. after death Director: Hospital 24 hours

Physician

/Medical

Examiner

Funeral

Director

na 23a or 28a-f ahor

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic avent, the Medical Expressions once.

Physician /Medical

Examiner

physician and the burial-transit

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Examiner

Physician/Medical

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Certification: To

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(Check only

29b. Signature and title of certifier

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

onel

29a. Certifier

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

with the Maryland

State Registrar

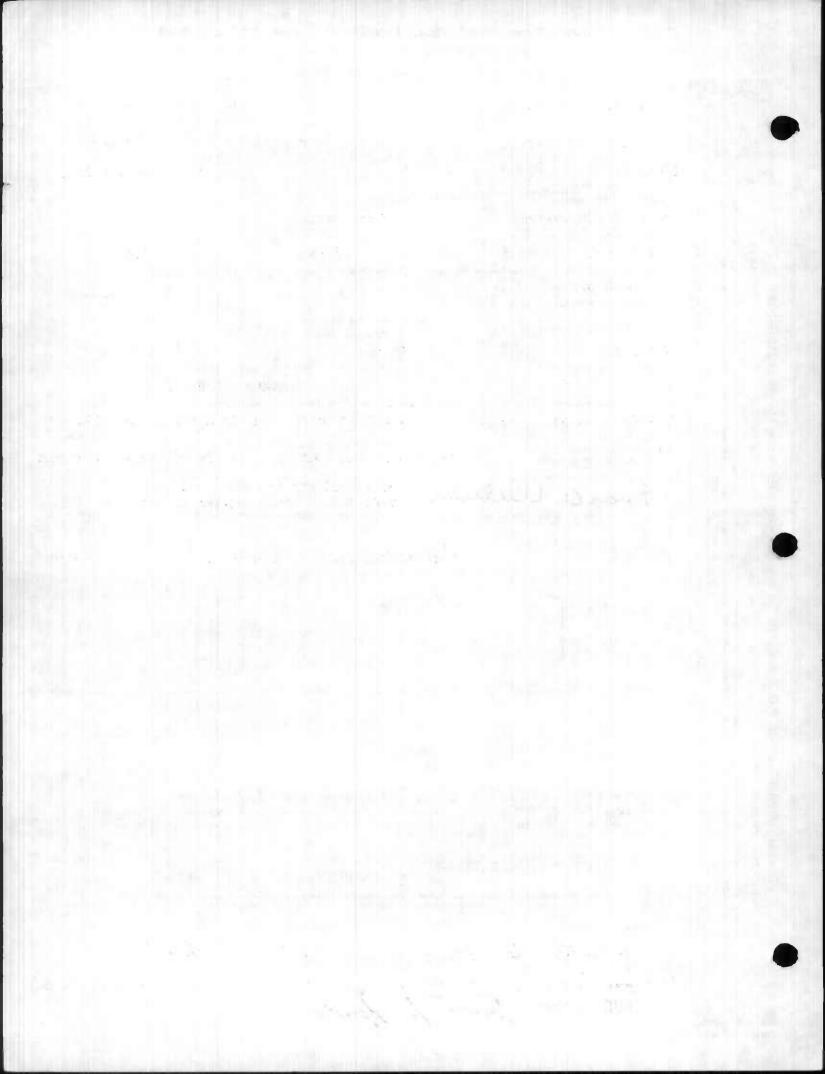
JOHN HUPKINI MEDILA CENTER BAYNEW CAMPI YTHO BALTON AVE NO 32 Registrer's Signature

ullden

regretations: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

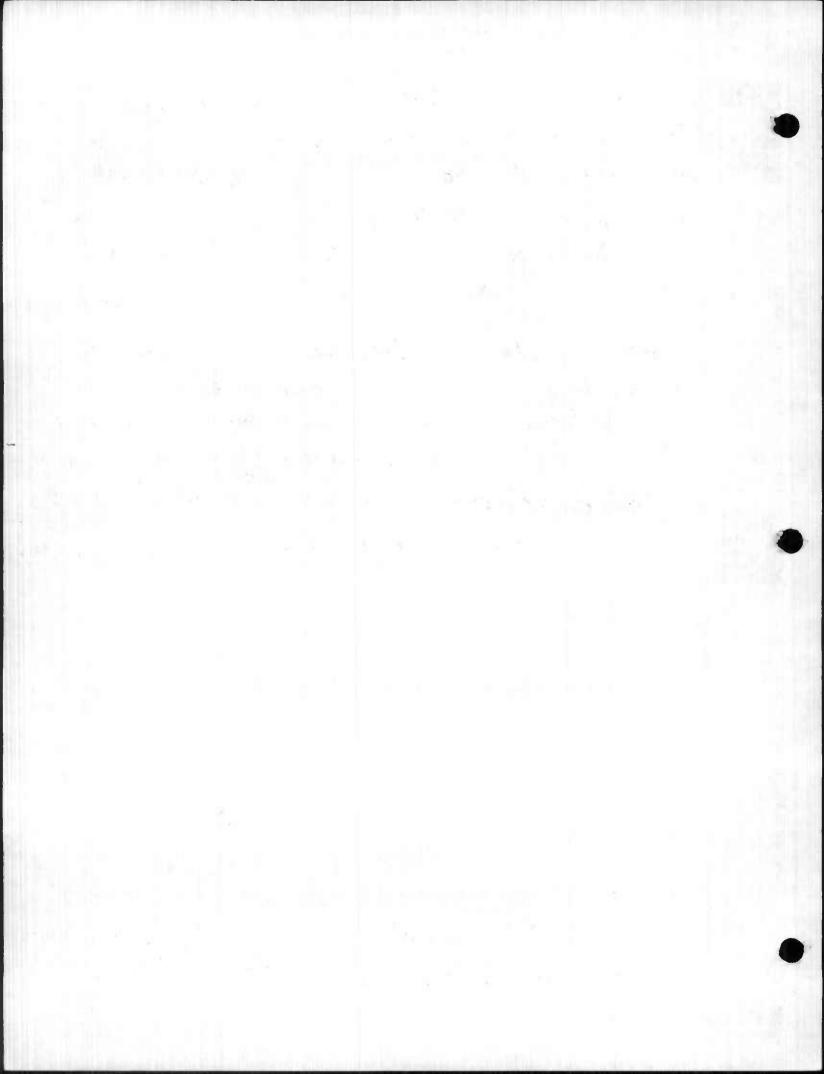
29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 2534

_		Certificate of Death	Reg. N		20041
Physici /Medic	al	1. Decedent's Namp (First, Middle, Last) Smith	2. Data of Death Month	7 1999	3. Time of Death
Examin	er		nore	c. County of Deet	h
Funeral Director		5. Social Sacurity Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 North Days Hours Min. 1 Usual Residence of Decedent	8. Data of Birth (Month, Dey./Yea 9/12/4	9. Birt	hplace (State or Foraig untry)
how		10a. State 10b. County 10c. City, Town or Location			10d. fnside City Limi
Sa-fa	Director	Md. N/A BAltiMORE			1 ¥ Yes 2 □ 1
with the	Dir	23 S. DA AS St. 21231	10g. C	Citizen of What Co	untry?
72 hours after death with the Marylend natural, or frams 23a or 28a-f ahow pical Examiner must be nuithed at	Funeral	11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? 1	ecity Yas or No- Rican, etc.)	14. Race - Ame Black, White	
natural',	d by	Tear or Dates:		Specify: D	ACK
- 4	Completed	15. Decadent's Education (Specify only highest grade completed) [Giva kind of work done during most of working the polynomial of the poly	ng 16b.	Kind of Business/	Industry
Z should be tiled within end Mentel Hygiena. Ia marked other than "sumatic avent, tra Men	E O	Elementery/Secondary (0-12) College (1-4or 5+) House work	4	Houseu	rife
d oth	Be	://:	(First, Middle, Maide		
2 should be end Mentel la marked of aumatic ave	10	William Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rura			Va Cadal
and 2 salth en n 27 la ler trau			Baltimore		21231
DO		20a. Method of Disposition 20b. Placa of Disposition (Nema of		Location - City or	Town, Stata
ment of h		1 A Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Cemetery 8	1/17/99 7	30 Himor	e, Md.
permit. Pag Depertment Important: If any Injury o		21. Signature of Fineral Service Licansee 22. Neme and Address of Facility Be	Hs Funer	al Home	-
	_	23a. Party The disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or	St. BAL	timore,	
busision		23a. Land the disease or complications that caused the death. Do not enter the mode of dying, such as cardlac or or heart failure. List only one cause on each line.	r raspiratory arrest,		Approximate Interval Between Onsat and Death
hysician /Medical	Н	Immediata Ceuse (Final diseasa or condition Esophageal Carc	moni	9	3 1/2 xe
Examiner		disease or condition resulting in death) Due to (or es e ensequence ot):			0
o ist	Examiner	b.			
cata be axecuted physician and s the buriel-transit	Exan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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ned by the e	Physician/	Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i.			to the cause of des
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s been s	Completed		24e. Was an aut performed?		Were sutopsy finding available prior to completion of causa of deeth?
ata h page	Con		1 🗆 Yes	2 XN0	Yas 2 No
	Be	25. Was case referred to medical examiner? Hospital: Hospital: Other: O	A		
al di	tion: To	27. Menner of Death 1 Senatural 5 Pending 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Work?	me 5 Residence 28d. Describe how in	8 Other (Specially occurred	cify)
within 24 hours after death, To the Funeral Director: After completely filled in by the funeral	Certification:	2 Suiside 6 Could not be	28f. Location (Street a City or Town, Ste	and Number or Ru te)	iral Route Number,
t houn	edicai	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	and due to the cause((s) and manner es	steted.
the F	Medi	one) and manner stated.			
* P 0		29b. Signature and title of certified 29c. Licensa number	29d. D	pata signed (Month	- 11 19
	-	30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 3001 S.	7)	CHA	001
		September 200 Parish and Assessed and Little Control (1996' Little)	VIVIV	~ \TY	
		GRYATH NIMMHGODDA Baltimore	MD	2122	5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** KASCHElle, SEMO AUJUST OIZO 99 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner Sinia Hospital Baltimare If Under 24 Hrs. 2401 W. Polvedere If Under 1 Year 8. Date of Birth (Month, Dey, Year) APR • 6,1906 Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 X F Yrs APR. 93 ROMANIA Director 121-50-9686 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medical Examinar must be notified as 1X Yes 2 No Directo MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 5900 PARK HEIGHTS AVENUE #203 21215 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic avent, the Medical Examiner must ponce. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates; Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ARON HERSCOVICI LEA GRUNBERG 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 304 WILLOW OAK CIRCLE - BALTIMORE, MD 21208 ADRIAN SEMO / SON 20e. Method of Disposition

1 Buriel 2 Cremetion 3 Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 8/12/99 ARLINGTON CHIZUK AMUNO BALTIMORE, MD 4 Donetion 5 Other (Specify) 21. Signature of Fundamental Society License 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. a 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and feilure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Pert1. Enter shock, or hy Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician end s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): hypothsion Physician/Medical that initiated events resulting in deeth) Lest Due to (or as a consequence of) 80 9SU 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 ☐ No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to Completed 24e. Was en autopsy performed? completion of cause of death? 2 No 1 Yes 1 Yes 2 No Be 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manger of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 - Homicide

The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, 0 signed by the e should page 2 has certificate Hospital or Attanding Physician: director. this funeral After deeth. ofter deeth Director: filled in by 24 hours e To the Hosp within 24 ho To the Fune completely fi

with the Merylend

altimore, Maryland 21215-0020

State Registrar

Medical

29e. Certifier

(Check only one)

29b. Signature and little of certifier

SEAN MCGACT,

31. Date filed (Month, Dey, Yeer) AUG 1 2 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

West BrivEdox Sinci Lospital, BAltimore, MD 21215 32. Registrar's Signatur

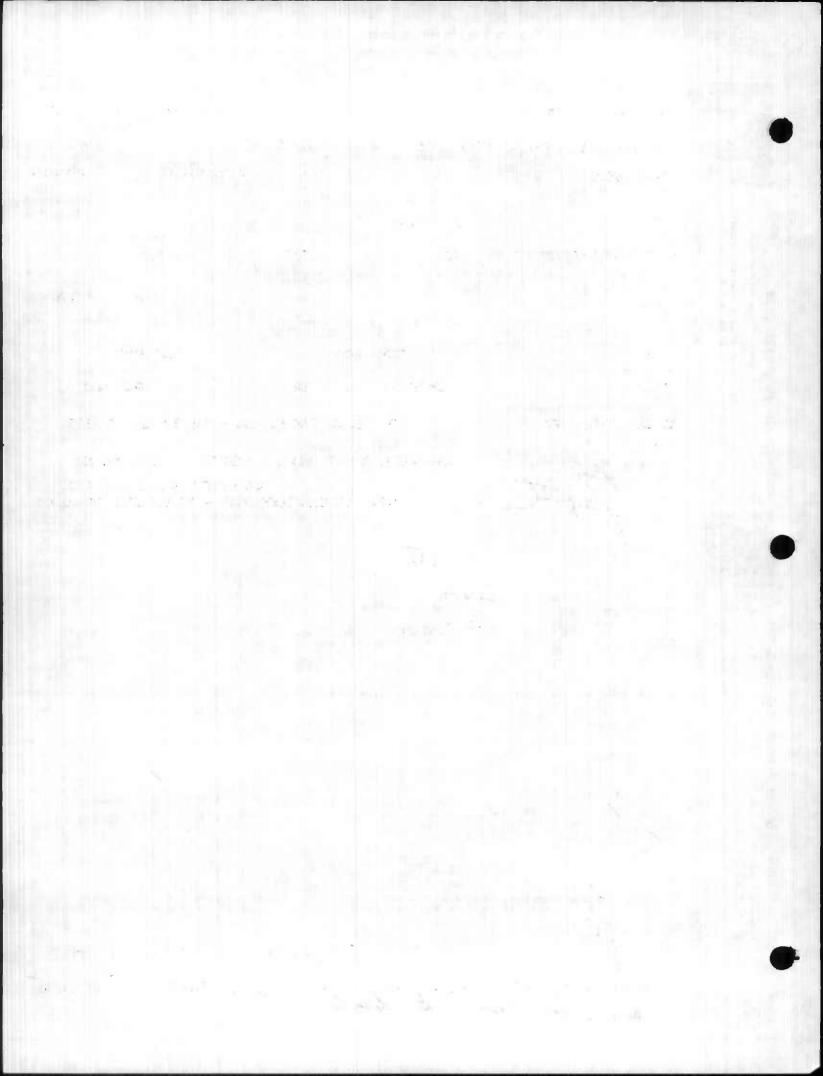
1🗹 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

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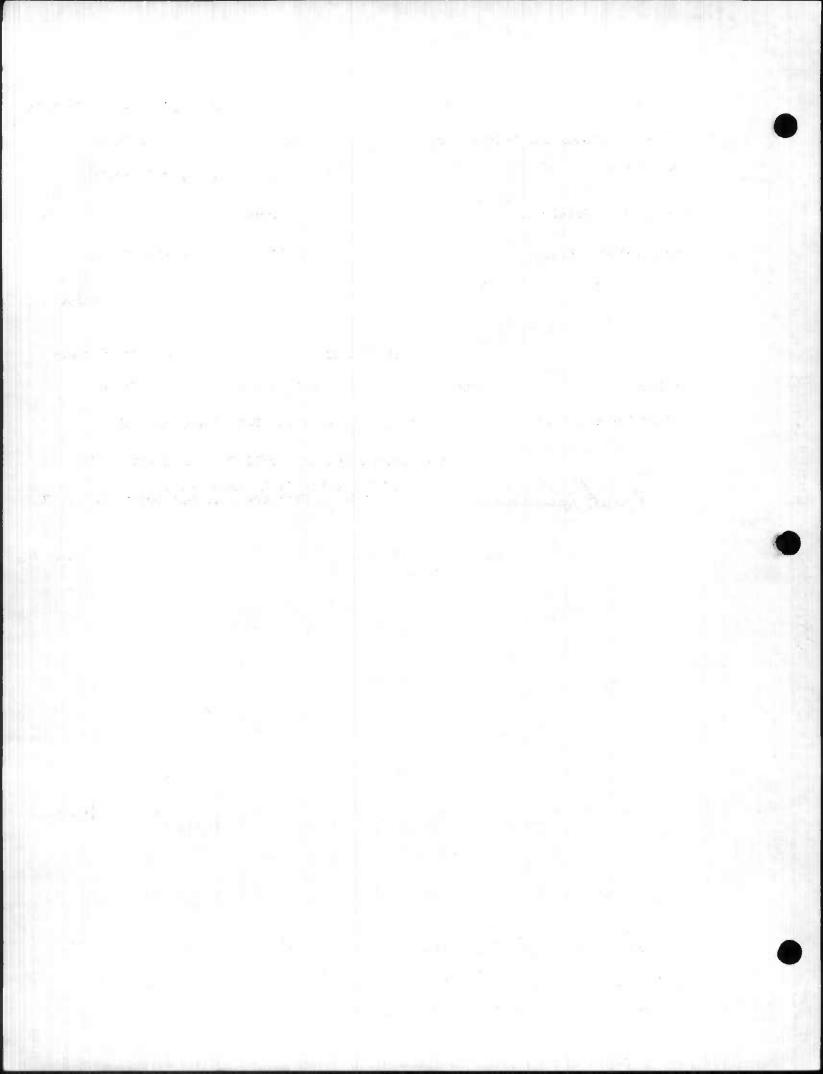
29d. Date signed (Month, Dey, Year)



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State of Maryland / Department of Health and Mental Hygiene

				,	Certifica	ate of L	Death	R	eg. No.	2	5343
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Funeral Director		5. Social Security Number 220 24 2452 Usual Residence of Decedent	M 2□F	76	Yrs. If Und Month	dar 1 Year ns Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 1	Year)	9. Birthp Coun Eng	plece (State or Foreign htry) Land
death with the Maryland ms 23s or 28s-f show	tor	10a. State 10b. County Maryland Baltim	ore	10c. City,	Town or Location		Baltimon	re		1	0d. Inside City Limits 1 ☐ Yes 2 No
th with the	ai Director	10e. Street end Number 5130 Alberta Ave.	1		10f. 2	Zip Code	21236	1	og. Citizen of V		
SAIT O20 Urs effer all, or the	by Funerai	11. Marital Stetus 1 Nevar Merried Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes:		If Yes, s	cedent of His pecify Cuber 2 No	spenic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-		e - Americ ck, White,	
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altimore, land perment of Heeli portant: If item 2.		20e. Method of Disposition		20b. Plea	ce of Disposition (A	leme of	T		20c. Locetion -		
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Baltimore, Marylar permit. Peges 1 end 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic as pace.		21. Signature of Europeal Service License	7		22. Name CAFA	end Addres Steph	_	ohrmann 1	P.A.		
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Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)	i	ng	CAnce						Intervel Between Onset end Death 13 month
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State	e	31. Dete filed (Month, Pex Veg 1999	32. Registrar	's Signetur	9. Spa	Ks				<i>'</i>	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dafa of Death Dorothy Anne Selander 8:05AM 4b. City, Town, or Location of Death 40 4a. Facility Nama (If not institution, giva street and number) 7. Aga In yrs. last birthday) PANES timore ITIMORE If Undar 1 Yaar 8. Data of Birth (Month, Day, Yaar) Feb 10, 1917 5. Social Sacurity Numbe Birthplaca (Stata or Foreign Country) Months Days Min Hours 216-01-9757 1 □ M 2 □ F Yrs 82 Maryland Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ∏Yas 2 No Baltimore Catonsville 10a Street and Numbar 10f. Zip Coda 10g Citizan of What Country? 709 Maiden Choice Lane U.S.A. 21228 12. Was Decedant Evar In U,S. Armed Forcas? 14. Race - Amaricen Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, afc.) I □ Yas 2 □ XNo If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married White 1 ☐ Yas 2 A No Specify: 3 DaWidowad 4 □ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Personal Secretary Westinghouse 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Ann Alashia Joseph Pappa 19a. informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 11 Prospect Bay Drive West, Grasonville, MD 21638 Patricia Gosselin (Niece) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Sfata 20a Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Meadowridge Memorial Park 8/12/99 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signatura of Funaral Sarvice Licansas 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 21228 1630 Edmondson Avenue, Catonsville, MD Lemmer 23a. Part1. Enfar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death Vascu unknown Dua to (or as a consequence of) Dua to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? 1 Yas 2 TLAK 1 Yas 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

rail, or items 23a or 28a-f show Examiner must be nutified at

permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Manial Hygiena. Important: if itam 27 is marked other than "natural", or itema 23, any injury or other traumatic avent, trail Madical Examera mana

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Director

Completed by Funeral

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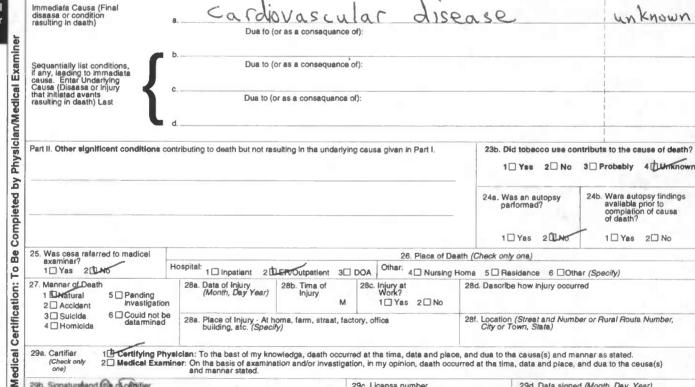
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Physician/Medical Examiner buniel-trensi physician s the buriel signed by the at d be detached for Completed by page 2 Be

or Attanding Physician: The law requires that the death certificete be executed Division of Vital Records. funeral director, After To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Al tha filled in by complataly i

> State Registrar

29b. Signature



son who complated ceusa of daath (Itam 23a) (Type, Print)

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29c. Licansa number

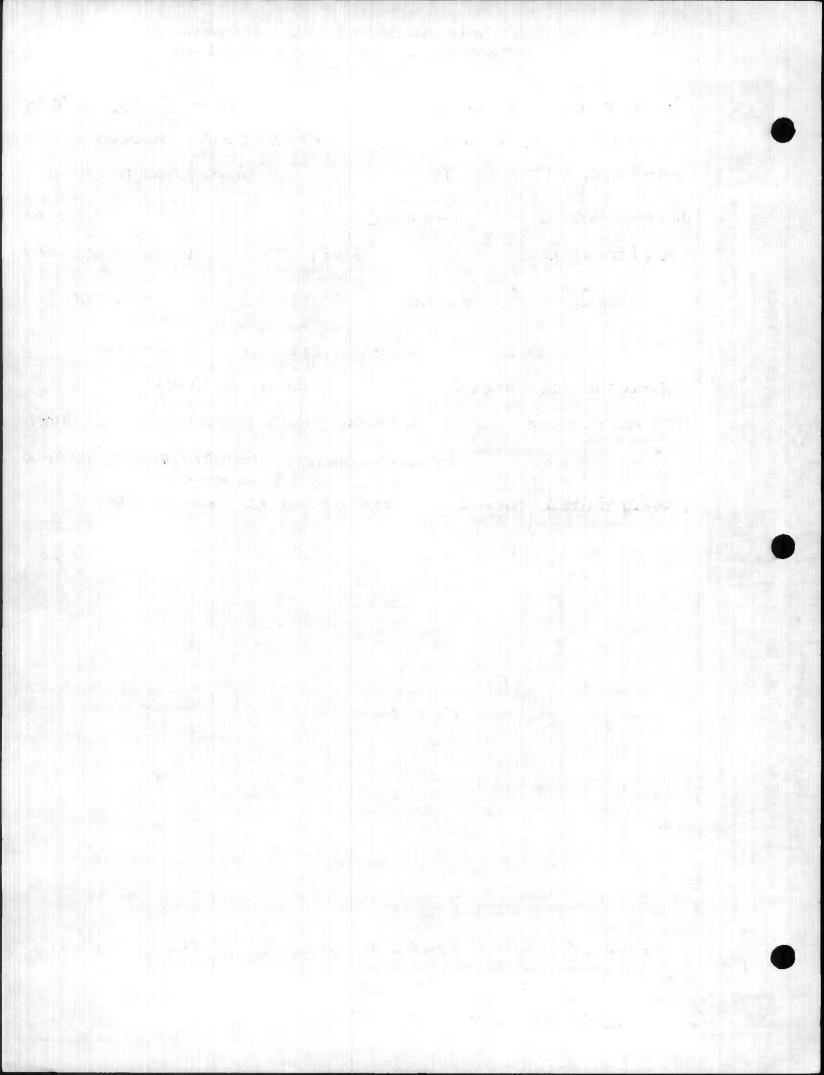
29d. Dafa signed (Month, Day, Year)

vie Lane, Baltimore, MD 21228

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death 1999 **Physician** HERBERT WALTER SPATH, JR. AUGUST 9:30 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAVRE DE GRACE HARFORD MEMORIAL HOSPITAL HARFORD If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 18 M 2□ F Yrs. 214-18-2619 AUGUST 3,1920 | MARYLAND Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND HARFORD KINGSVILLE 1 ☐ Yes 2 No Director 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2611 RECKORD ROAD UNITED STATES OF AMERICA 21087 Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Merital Status the Medical Examiner 1 Yes 2 No If Yes, Give Yeer or Detes: 1944-1946 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 B No Specify: Specify: WHITE ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent'e Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BANKING EXECUTIVE VICE PRESIDENT 2 YEARS 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) should be not Mental in AMALIE A. KUNST HERBERT WALTER SPATH, SR. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2611 RECKORD ROAD KINGSVILLE, MARYLAND 21087 Health Item 27 MILDRED D. SPATH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 75 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY AUG 14,1999 BALTIMORE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ALTENBURG FUNERAL HEME, PA. 21. Signature of Funeral Service Licenses 230 P.M.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one case line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequenca of): Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): Physician/Medical that initiated events resulting in death) Lest Due to (or es e consequence of): Spart, Herbert Wolton Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown non-Hodgpins ģ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) To Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only within 2 To the F 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) de la D14036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RENE P. DE 105 SANTS

State Registrar 31. Dete filed (Month, Day, Year)

32. 'Registrar's Signaturé



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death Month Dorothy Mary Sangtinette 10, 5:30 a.m. August 1999 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Cromwell Elder Care Baynesville Baltimore If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 1 M 2 X F Months Days Hours Min 218-38-3157 95 Yrs. New York 1903 Usual Rasidance of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Parkville 1 ☐ Yas 2 X No Baltimore Md. 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 21234 8401 Nunley Drive United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yaa or No-ff Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 11. Marital Status 1 Yaa 2 No If Yes, Giva Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No Specify: Specify White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grads completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Adolph Rieger Mary Heisser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 8401 Nunley Drive Apt. F Baltimore. Md. Dorothy S. Hoibroten (Daughter) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 8/13/99 Moreland Memorial Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funaral Service Loomsee Milton J Knight Jr 22. Nama and Addrasa of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximata Intarval Betwe Onsat and Death Immediata Causa (Final diseasa or condition resulting In death) BLEEDING CHASTRO INTESTINAL Dua to (or as a consequence of): DISCEASE. CORONARY Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated eventa rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying ceuss given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Onknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopay performed? 1 Yes 2000 1 ☐ Yes 2 ☐ No 25. Was cesa refarred to medical examinar? 26. Place of Death (Check only ona) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27, Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 D Natural 1 Yas 2 No 2 Accident 6 ☐ Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, atreet, factory, office building, etc. (Specify) 4 Homicide 1 Evertifying Physician: To the best of my knowledge, deeth occurred at the tima, data end place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

certificate be executed Box 68760. P.O. Division of Vital Records. To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After t

Physician

/Medical

Examiner

Funeral

Director

the Medical Examiner must be notified

2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural", or than

permit. Pages 1 and 2 sh Department of Health and Important: If them 27 is me any injury or

Physician /Medical

Examiner

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29e. Certifier (Check only one)

29b. Signatura and Affile of certifier

State Registrar

VIPUL KUMAR 3007 32. Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

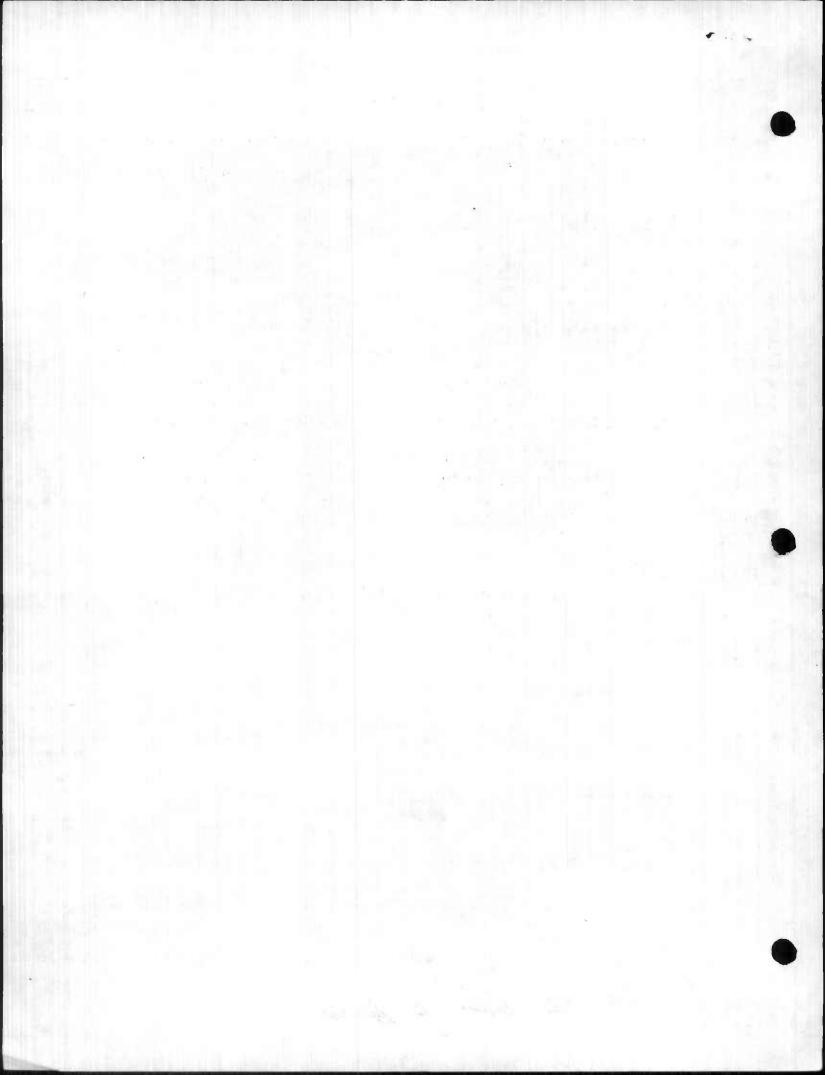
E. MORTHERN PKWY, BALTIMORE, MID 21214 oaks

29c. License number

052228

29d. Date signed (Month, Day, Year)

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Gertrude Marie Staiti 6:52 P.M. August 7, 1999 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give streat and number) 4c. County of Death **Baltimore** Hammonds Lane Center - Genesis Eldercare Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1□ M 20 F Months 87 February 27, 1912 Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Howard Ellicott City 10g. Citizan of Whet Country? 10f. Zip Code 21042 3342-G North Chatham Road U.S.A. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Bace - American Indian. 1 Yas 2 No If Yas, Giva Year or Dates: 1 Never Marriad 2 Married 1□Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Self-Employed College (1-4or 5+) Elemantary/Secondary (0-12) Beautician 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumeme) John Adam Bauer Mary Viola Dobbin 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Code) 3397-G Littleton Way Pasadena, Maryland 21122 Ms. Elizabeth Viola Mack Neice 20b. Placa of Disposition (Nama of cemetery, crematory or other placa) 20c. Location - City or Town, Stata Burlal 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Spacify) 08/10/99 Baltimore, Maryland **New Cathedral Cemetery** 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvica Licensae Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Entar the disease, or complications that caused the death. Do not anter the mode of dylng, such as cardiac or respiratory arrest, shocky or heart feiture. List only one cause on each line. Approximate Interval Batween Onset and Death cardiac arrhythym o butmetive lying disease 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably TO Unknown ANEMIA

Physician /Medical Examiner

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Completed

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Certification:

Medical

attending physician

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24 hours after death. Funeral Director: Af

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Division of Vital Records, P.O. Box 68760,

Injury or

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Physician

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic svent, the Madical Examinal must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23.

altimore, Maryland 21215-0020

the Maryland

5. Social Sacurity Number

10a. Stata

Maryland

10e. Street and Number

20a. Method of Disposition

Director

Funeral

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Usual Rasidance of Decedant

216-03-9697

Examiner Sequantially list conditions, if eny, laading to Immadiata cause. Enter Underlying Couse (Diseasa or injury that initioted avents rasulting in death) Last Physiclan/Medicai

Immediata Ceusa (Final diseasa or condition rasulting in death)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 100 25. Was casa rafarred to medical examinar? 26. Place of Deeth (Check only ona) 1 Yas 2 No Hospital: Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Dascribe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Spacify) 4 Homicida

29e. Certifier (Check only one)

1 De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29b. Signatura and titla of cartifiar

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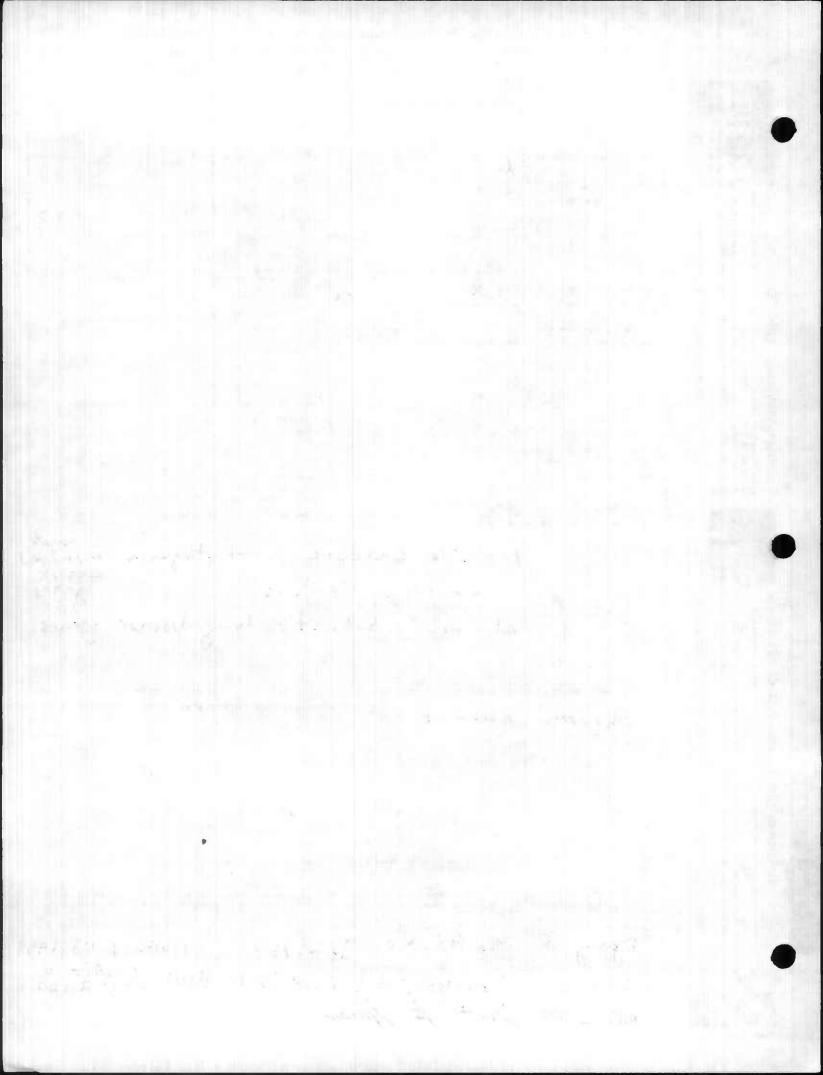
29d. Data signed (Month, Day, Yeer)

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

M.D. 8418 B+A KARBEK 32. Registrar's Signatura 31. Dete filed (Month, Day, Yaar)

bek, M.D

Registrar



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State of Maryland / Department of Health and Mental Hygiene

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M 1 □	Yes 2□No				
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00	estigation, in my o	estigation, in my opinion, daath occurred	estigation, in my opinion, daath occurred at the time, date	estigation, in my opinion, death occurred at the time, date and place, a	cocurred at tha tima, data and place, and due to tha causa(s) and mannar as statad. estigation, in my opinion, daath occurred at the time, date and place, and due to the company of the c

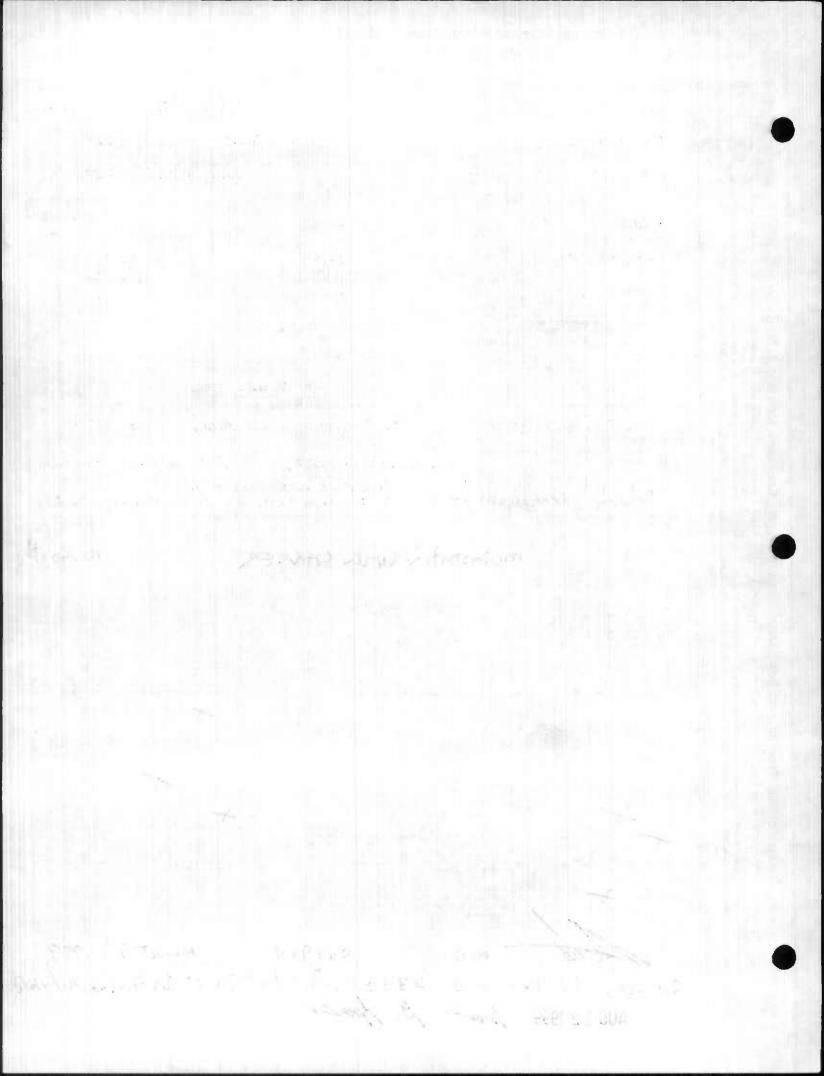
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State of Maryland / Department of Health and Mental Hygiene O O

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9, Katherine Richards Tillman August 1999 4:29am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Blakehurst Towson Baltimore If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 10 M 201 Yes 215-32-8723 95 Sept.6,1903 Balto.MD Director Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 1 ☐ Yes 2€ No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1055 W. Joppa Road 21204 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If Itam 27 is merked other than "natural", or items 23s any injury or other traumatic avent, tra Medical Empirier mast page. Funeral 12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ZXNo If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Webster Cox Richards Edith Sindall 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9613 Labrador Lane Cockeysville, MD21030 H. Richards Tillman - son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1⊠ Burial 2 ☐ Cremetion 3 ☐ Removel from State 8/12/99 Baltimore, MD Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home. Inc. Mitchell 6500 York Road Baltimore, MD 21212 23a Pin1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Deeth **Physician** Immedieta Causa (Final disease or condition resulting in death) MYOCARDIAL F /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner CVP physician and the bunal-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) 88 signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, þ ficate has been sign, r, page 2 should b 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24e. Wes en eutopsy 1 □ Yas 2 □ No 1 Yas 2 1 NK certificata Division of Vital or Attanding Physician: director, 25. Was casa refarred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatien1 2 ER/Outpatien1 3 DOA this funeral 27. Manner of Death 1 Netural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Affer 5 Pending investigation n 24 hours after death.
he Funeral Director: Aft
bletch filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours aft To the Funeral Di completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) ş 29b. Signeture find title of celtifler 29c. License number 29d. Date nigned (Month, Day, Year) 90 6 nu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Daniel G. Sapir 10755 Falls Road, Timonium, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 2 1999

DHMH 16 Rev 6/95

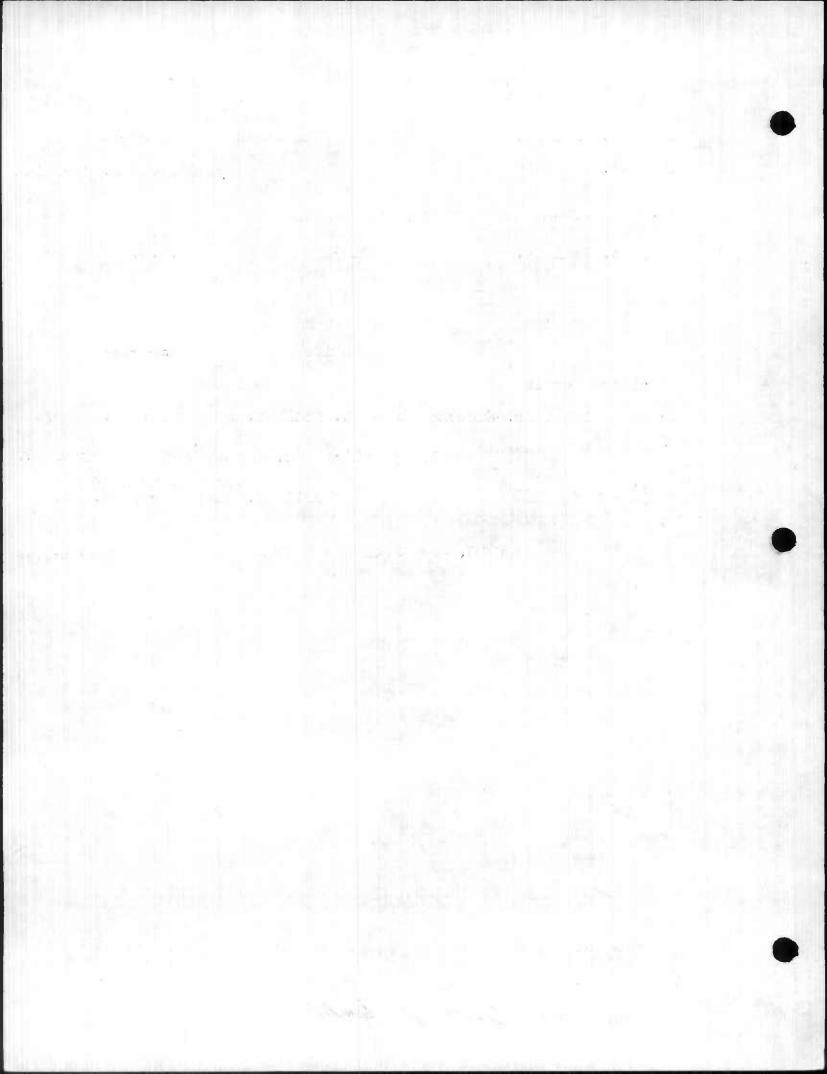
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	State of Maryland / Department of Health and Mer	ntal Hygiene Q	2535
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Medical aminer	4a Facility Name (If not Institution, 1632 St. Pau			4b. City, Town, or Hampste	Location of Dea	,	of Death			
r	5. Social Security Number 215-32-0147 Usual Rasidence of Decedent	Y .	ge (In yrs. last b 79	Yrs. If Und Month	der 1 Yaar s Days	If Under 24 Hrs Hours Min.	8. Data of B (Month, D Sept	26,191	9. Birthpl Count	lace (Stata or Foraig try) Carolin
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à	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1	Ever in U,S. No		pedent of I pecify Cub 2 No	dispanic Origin? (S an, Mexican, Puer Specify:	pecify Yas or N to Rican, atc.)	o- 14. Rad Bla Specif	ce - America ck, Whita, a y: Wh:	
Completed	15. Decedent'a (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or			work done use retire	during most of wo d)	rking	16b. Kind of B		ustry
To Be C	17. Fathar's Nama (First, Middla, La Willard Nor						ne (First, Middle nel Isa	a, Maiden Sumar	ne)	
	19a. Informant's Name/Relationship Richard Trimb	(Type, Print) Le Sr. Hu	sband	b. Mailing Address 1632	St.	Paul St	• Hamp	ber, City or Town Stead,	, Stata, Zip Md •	code) , 21074
	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	cernet	of Disposition (finery, crematory of ney Va	r other pla	Mem.	ug 14,	20c. Location 1999		wn, Stata nium, Mo	
	21. Signature of Funeral Service Lie	ensee	1					Funer chester		hapel . 21102
VMedical Examiner	fmmediata Causa (Final diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	a. Par b	Due to (or as a	consequence of	of): of):	Cancer				11 month
Physician/	Part fl. Other significant conditions	contributing to death b	out not resulting	in the underlying	g causa gi	ven in Part f.				the cause of death
rector, page 2 should be deteched by the page 2 should be deteched by Bhysical Be Completed by Physical Be Completed by Physical Be Completed by Physical Beauty States and Stat							per	s an autopsy lormed?	ava con of c	are autopsy findings allable prior to impletion of cause death?
o Be	25. Was case referred to medical axaminar? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/C	hytostiant 2	DOA OI	26. Place of De		one) sidenca 6 ⊡Oti	nos (Consili	d
completely filled in by the funeral director, Medical Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could no determine	Time of Injury M farm, atreet, fact	28c. Inju Wo		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medical Co	29a. Certifier (Check only one)	Physician: To the best aminer: On the basis o and manner st	f axamination a	e, death occurrend/or invastigati	ed at tha ti on, in my	ma, data and place opinion, daath occu	a, and dua to the arred at the time	a causa(s) and m	anner as st	ated. the cause(s)
M	29b. Signature and title of certifier	Chin	hos	(Type, Print) Hampstead A land				29d. Data signed (Month, Day, Year) 08 - 11 - 99		
State	30. Nama and addrass of person what 423 / Nouth 31. Data filed (Month, Day, Year)	moods	Thai	(Type, Print)	K lace	Hamps	tead	mg 2	1079	2



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2325 RONALD PAUL UPPERMAN August /Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Union Hospital Elkton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Ye Sept. 14, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Director 171-30-6299 60 Yrs 1938 Pennsylvania Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 23a or 28a-f ehow must be notified at Director 1 ☐ Yes 2 ☑ No Maruland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 91 Ridge Run Road 21901 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effar to Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or harmy injury or other traument. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ρ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Community College Professor years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul E. Upperman Juanita Weiler 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruthann B. Upperman (Wife) 91 Ridge Run Road, North East, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🕱 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/11/99 Hershey, Pennsylvania Hershey Cemetery 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.

12. Mac Phail Road, Bel Air, MD. 21 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Betw Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical as a consequence of) attanding p signed by the a Part il. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ cata has been sig Completed 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No director, Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil Medical 29b. Signature and title of cogifier 29c. License number 29d. Dete signed (Month, Day, Year) 1003782 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

the Mandend

Baltimore, Maryland 21215-0020

Herns 23a

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After

Funeral

Hospital or Attending Physician: 24 hours after death.

Box 68760,

P.O.

Records,

Division of Vital

31. Date filed (Month AUG 12

J. Goodill M.D.,

106 Bow Street. 32. Registrar's Signature

Elkton, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Realth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of the AUGUST 8, 1499 **Physician** 2:45 M 1) ALSTRIA /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 289 F 498205066 Yrs. 10P1 1907 Director IARY Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-f show 1 Yes ZNNo Directo BALTIMORE MARVERIO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with KOAD 21234 . A 880 death 12. Wes Decedent Ever In U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Meritel Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Bleck, White, etc. 1 Never Married 2 Married 1 Yes 219 No Specify: 20 318 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry end Mental Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Homs 127RS-HOMEMAKER altimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Valstrum Be end 2 should be ealth end Mental GRACE HAYDER BERNARO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31334 permit. Peges 1 end 2 : Department of Health er Important: if item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, cremetory or other place) EDWARD A. WALSTRU JARYLAND 20a. Method of Disposition Date 20c. Location - City or Town, State AUG IL Burial 2 Cremation 3 Removal from State 4 Quonation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility 31234 ORILL EVANS CHAPILO 8800 HARFORD KORO ON PLY SA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahook, or heart failure. List only one cause on a ph line. Approximate Interval Between Onset and Death **Physician** 4 DAYS ASPIRATION PNEUMONIA /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner 4 DAYS UROSEPSIS the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): certificate be exec YEARS CEREBROVASCULAR ACCIDENT WITH physician P.O. Box 68760 Physician/Medical Due to (or as e consequenca of): 98 attending p YEARS DECEREBRATE RIGIDITY signed by the al Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2⊠ No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed 1 ☐ Yes 2 No certificate 1 🗆 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2N No Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident i or Attend efter death Director: / 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide e Hospital of 24 hours ele Funeral D 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-25886

M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

LILIA CEBALLOS,

AUG 1 1 1999

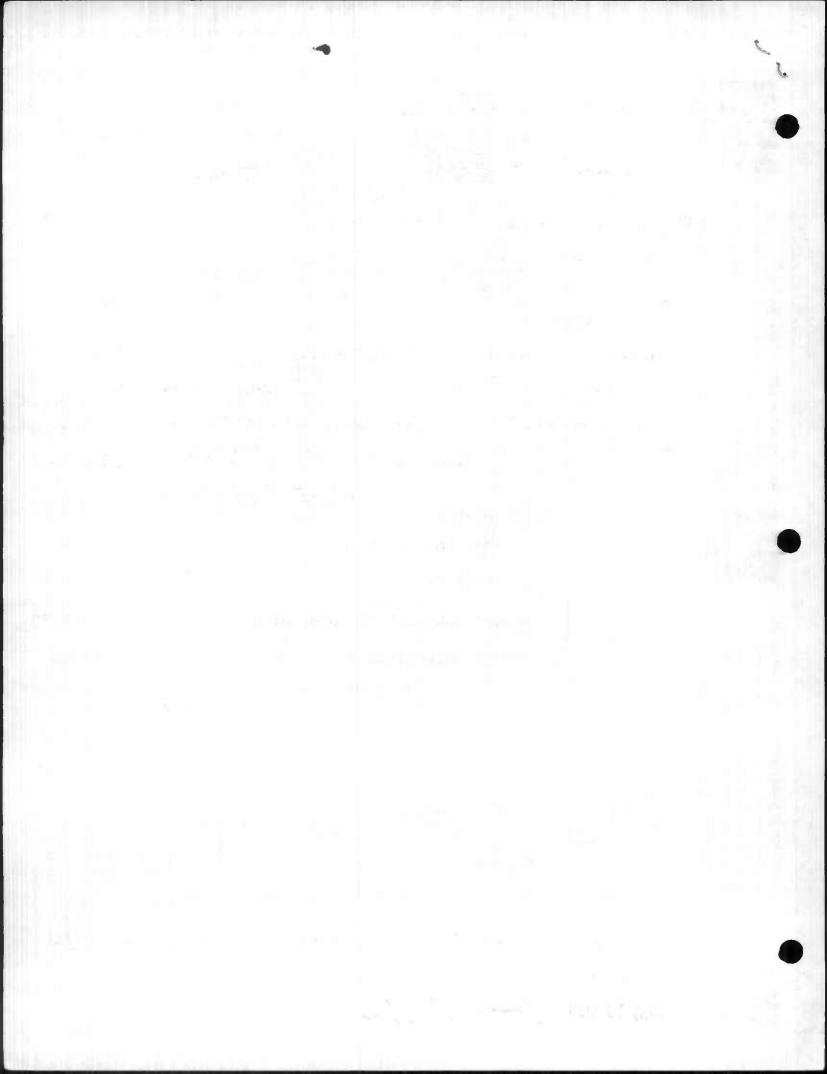
31. Date filed (Month, Day, Year)

41410

DHMH 16 Rav 6/95

State

Registrar



Please Type or Print in Biack Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Norma Jean Woodu 12:49 AM Hugust 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Square enter tranklin Hosbita asedale If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 31, 1 9. Birthplaca (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex Months Days 1□M 20 F 233-70-8717 56 1942 West Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits 1. Yas 2□No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1058 Armistead Way 21205 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 Nidowed 4 □ Divorced White 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Frank Stimac Jr. Irene Lutian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1056 Armistead Way, Baltimore, Maryland 21205 George Woody Jr. (Son) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 8/13/99 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee yrous 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) 27 Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) Weeks Fail Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? Obstructive Pul Monary Disease completion of cause of death? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Suppatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yas 2 ☐ No

Examiner Examiner physician and the burial-transit that the death certificate be executed P.O. Box 68760 Physician/Medical Records, Completed by The law requires Division of Vital Be Certification: To this After Attending n 24 hours after death.

Ne Funerel Director: After pletely filled in by the fun 6

Physician

/Medical

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Hygiene.

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reportant: If Item 27 is marked other

Physician /Medical

25. Was case referred to medical axaminer? 1 Yes 25 No

27. Manner of Death 1 Accident 5 Pending Investigation

6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) AUGUST 11, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DY Anthony Samphilipo 9000 Franklin Drive Baltimore, Maryland 21237 82. Registrar's Signature

State Registrar

Medical

DHMH 16 Rev 6/95

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AUE 12 1953 Seem of Johnson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth OW 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death Month. FRANK JOHN YURKANIN 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, giva street and number) 4c. County of Death Mariner Health of Bel Air Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) 10 M 2 F Months Deys Hours Min. Yrs. 170-09-7503 Oct. 4, 1917 Pennsylvania Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No MD. Harford Fallston 10f. Zip Code 10e Street and Number 10a. Citizen of What Country? 2718 Pleasantville Road 21047 U.S.A. 14. Rece - Amaricen Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 11. Meritei Status 1 X Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 Ves 2 No Specify: 3 Widowed 4 Divorced White. 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiamentary/Secondary (0-12) College (1-4or 5+) 8th grade Die Setter Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John Yurkanin Elizabeth Katruba 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Name/Reletionship (Type, Print) 2718 Pleasantville Road, Flora L. Yurkanin (Wife) Fallston, MD. 21047 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 8/14/99 West Newton, PA. West Newton Cemetery 21. Signeture of Funerel Service Licenses 22. Name end Address of Facility Schimunek Funeral Home of Bel Air, 610 W. MacPhail Road, Bel Air, MD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 21014 Approximate intervel Between Onset and Death eight months Immediate Cause (Final disease or condition resulting in deeth) Metastatic Carcinoma Gastric Due to (or es e consequença of) Due to (or as a consequence of): Due to (or as e consequenca of). 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 LUnknown 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

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r is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinal must be notified as

permit. Pages 1 and 2 should be filed within 72 hours aftar death v Department of Haelth and Mental Hygiena. Important: If item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Medical Examplement once.

Baltimore, Maryland 21215-0020

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Sequentially list conditions, if eny, leeding to Immadiate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest

> 1 ☐ Yes 2 ☑ No 28. Piece of Deeth (Check only one) Other: 4 M Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred

ed to medical
No
5 Pendin

2 Accident

3 Suicide

4 T Homicide

28e. Dete of Injury (Month, Dey Year) Pending investigation 6 Could not be determined 28e. Pieca of Injury - At home, ferm, street, fectory, office building, atc. (Spacify)

1 inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one)

1🔀 Certifying Physician: To the besi of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as stated. 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signature and little of certifier

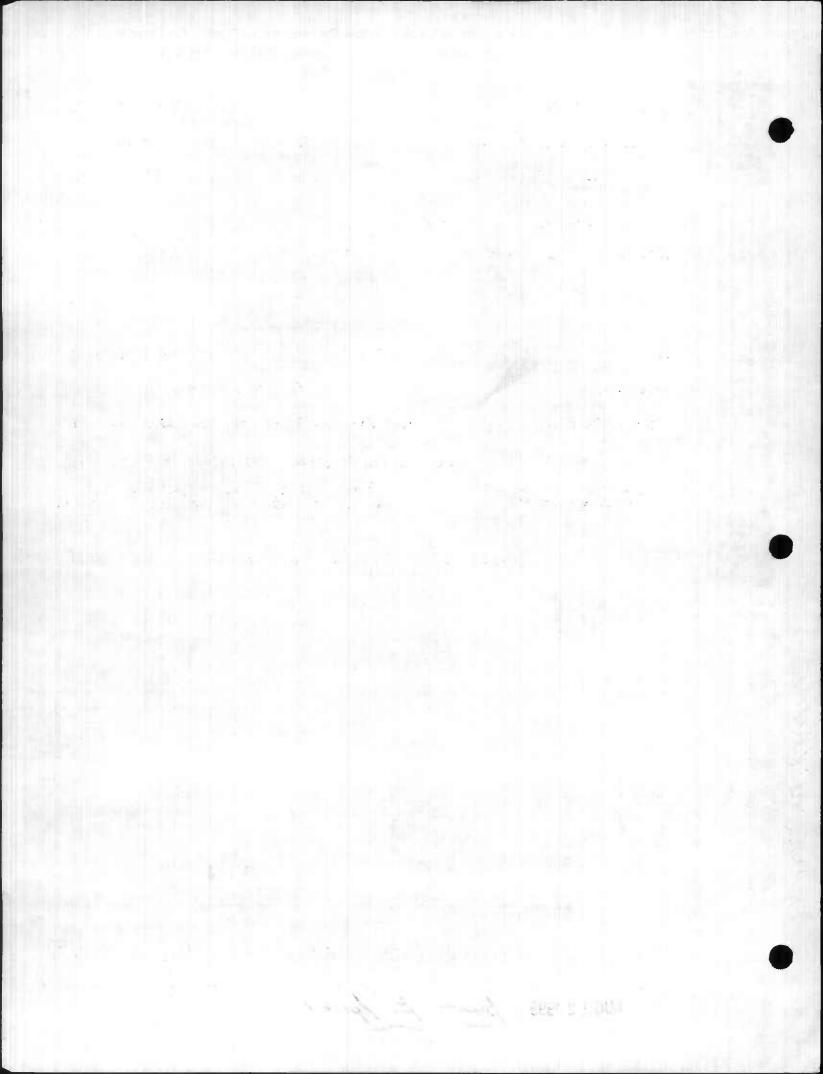
29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ma Ort 5522 august Bel Air Maryland

State Registrar

DHMH 16 Ray 6/95

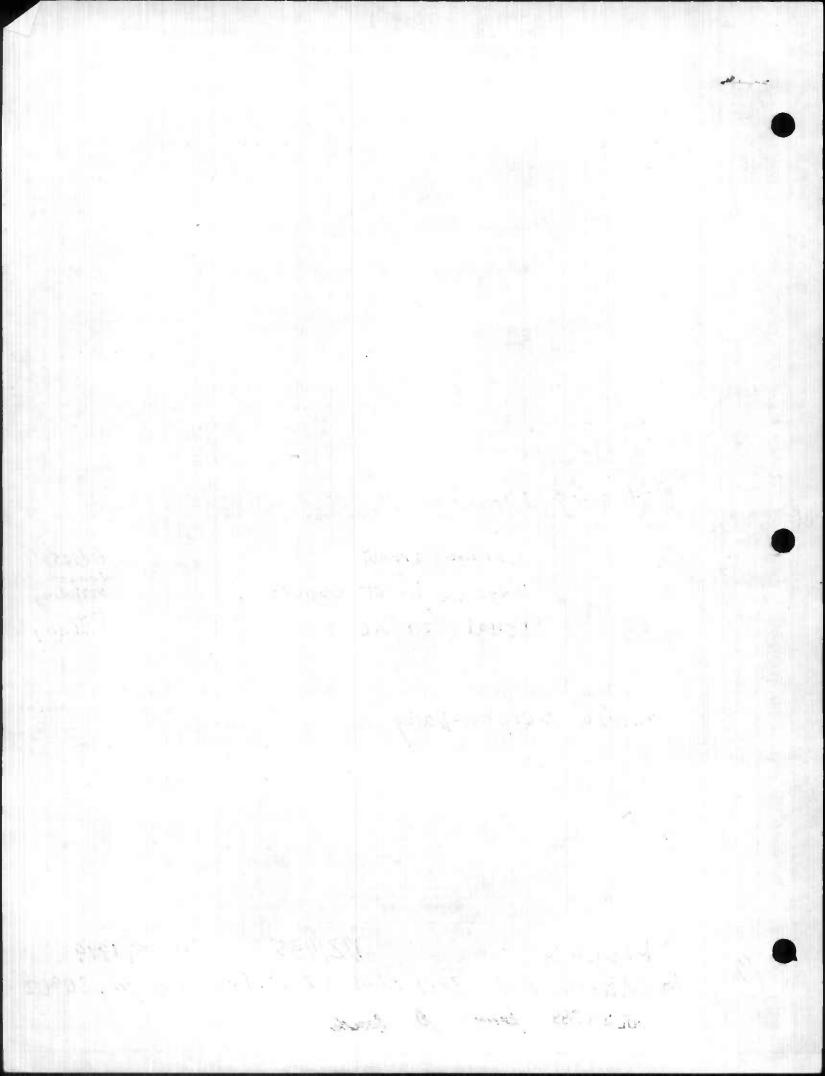


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Yaar **Physician** Norman L. Avery 07 99 26 6:45 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring, Md. Montgomery 9. Birthplace (State or Foreign Country) If Under 1 Yaer | If Under 24 Hrs. | 8. Data of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Sociel Sacurity Numbar 7. Age (In vrs. last birthday) **Funeral** Days 1⊠M 2□ F Months 577-74-7468 46 Director 07-08-1953 Wash., Usual Rasidence of Decedani 10a Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 11 Yas 2 □ No Director Montgomery Kensington 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? herma 23a or 3000 McComas Avenue 20902 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No 11 Marital Status 14. Race - American Indian. Black Whita atc 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Hygiene. Collega (1-4or 5+) Elamentary/Secondary (0-12) Cook Private Industry 11 permit. Pages 1 and 2 should be the Department of Heath and Mental Hy important: if Nem 27 is marked other any Injury or other to 17. Fethar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumema) Be B Hillard Johnson Willie Lee Avery 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Nathaniel Avery/Brother 1605 Trinidad Ave., NE Wash., DC 20002 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata Data 1 X Burlat 2 Cramation 3 Ramoval from Stata Forest Hills Cemetery 7/30/1999 Clinton, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funeral Service Licenses 22. Nama and Addrass of Facility Tyrone J. Young Funeral Services 719 Kennedy Street, NW Wash., shock, or haart failura. List only ona causa on aach line. 20011 Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disaasa or condition rasulting in death) Cardiac arrest 600V5 Examiner 1009-Examiner congestive heart physician and the burial-transit Sequentially list conditions, if any, leeding to immediata causa. Enter Underlying Causa (Disaasa or Injury that initieted avents rasulting in death) Last Due to (or as a consequence of) Box 68760. tailure Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown encephalopathy þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was casa raferred to medical axaminer? Be 26. Placa of Death (Check only ona) Hospitel: To Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yas No 17 Inpatient 2 ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Day Year) 27. Mannar of Death or Attending Piatter death.

Director: After the Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation 1 Yes 2 No 2 Accidant 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide within 24 hours a To the Funeral D Hospital 29a. Certifie edical 🖎 Certifying Physician: To tha best of my knowledgs, death occurred at the time, date and place, and due to the causa(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted. 29b. Signature and titla of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) Medial Park Drive Silverspring 20902 no complated causa of death (Itam 23a) (Type, Print) 2101 31. Data filed (Month, Day, Year) 32. Registrar's Signeture JUL 3 0 1999 Registrar

DHMH 16 Ray 6/95

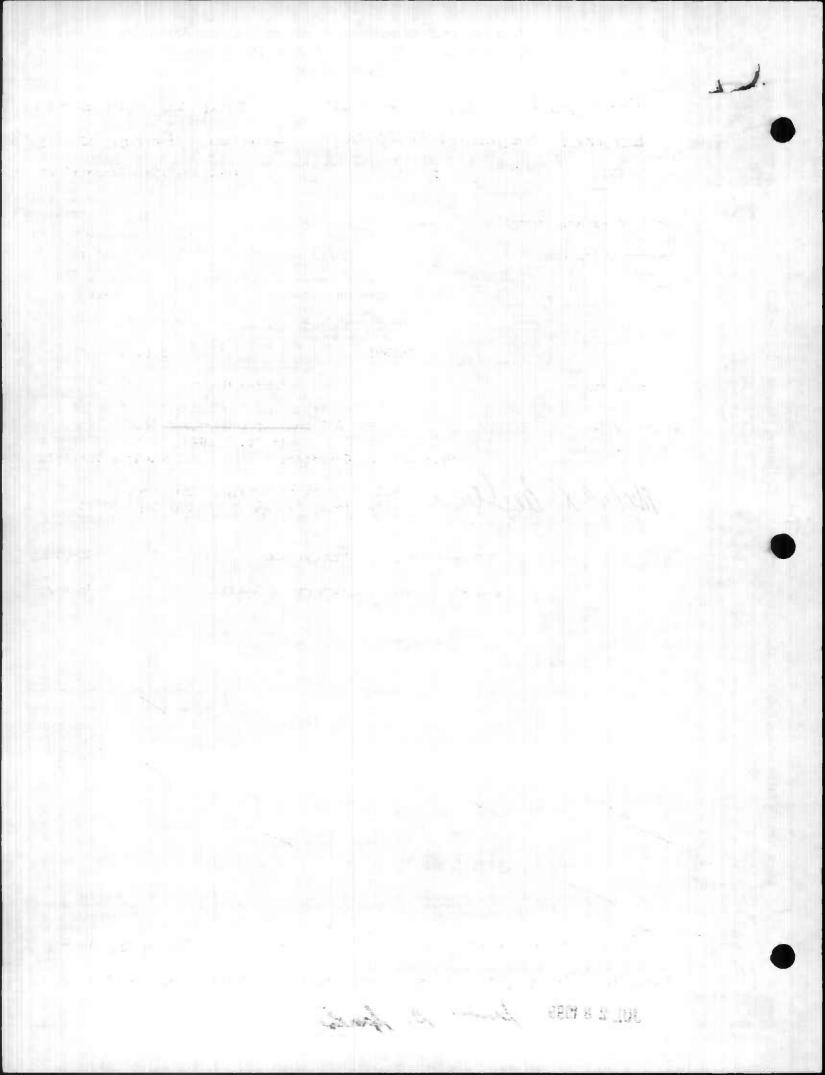


Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

		Amended Item 19b, 8/3/99, barm Certificate of Death	ental Hygie	ene 99 2	25357		
		1. Decedent's Name (First, Middle, Last)	2. Date of Deeth		3. Time of Death		
	Physician /Medical	DORIS MARIE ATKINSON	Month July	Day Year 1999	06:30 AM		
	Examiner	4e Facility Name (If not institution, give street end number) 4b. City, Town, or Loc	cation of Death	4c. County of Death			
10		1440 Belvedere Road Port Depo	osit	Cecil			
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth (Month, Dey, Y	(ear) 9. Birth	place (State or Foreign intry)		
н	Director	213-58-3037	September 2	25, 1921 Ma	aryland		
	Pu B	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. inside City Limits		
	ahow				1 ☐ Yes 2 ☑ No		
	or 28a4 e	Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?				
	with po of						
	r flame 23	1440 Belvedere Road 21904	cify Yes or No-	United S	tates		
5-0020	n 72 hours efter death with the Manyand "natural", or items 23s or 28s-f show ideal Evantive must be notified at leted by Funeral Director		Rican, etc.)	Black, Whita	, etc. hite		
0	led within 72 ho bygiene. The then "nature it, the the deal Completed	15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business/li	ndustry		
21		(Specify only highast grade completed) (Give kind of work dona during most of working life. DO NOT use retired) (Give kind of work dona during most of working life. DO NOT use retired)	ng				
2121	Hygiene. ther than and, the the	8 Homemaker		Her own H	ome		
pu	tal Hyging of other avant, Be Co		(First, Middle, Ma	iden Sumama)			
yia	2 should be filled within and Mental Hygiene. Is marked other than aumatic avant, the Ma To Be Comp	William Clayton Bessie	Lamar				
Maryiand	0 9 9 9	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural 1704	l Route Number, C	City or Town, Stata, Zi	ip Code)		
	E = N L	Delbert W. Atkinson, Jr. / Son 1794 Belvedere Road, Po	ort Depos	it, MD 2	1904		
0	S of H	20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Place of Disposition (Name of cemetery, cremetory or other place) J1	uly 31 20	c. Location - City or T	own, State		
ti m	Lant: Pe	4 □ Donation 5 □ Other (Specify) Bethel Cemetery		orth East	, Maryland		
Baitimore,	permit. Peg Department Important: I any injury o pnce.	21. Signature of Funeral Service Ricensee 22. Name and Address of Facility Crouch Funeral Home					
_	40 E 6 0	127 South Main Stree	et, North	East, MD	21901		
	Physician /Medical Examiner	23a. Párt1. Entar tha disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of):	Tophatory arrost	, 1 1 1 1 1	Approximata Interval Batween Onset end Deeth		
Box 68760,	us the death certificate be executed by the attending physician and letached for use as the burlet-transit Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of):					
	death od for sicial	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	ecco usa contributa	to the cause of death?		
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of Vitai Records,	been should		24a. Was an a performe	d? a	Vere autopsy findings vailable prior to ompletion of cause f death?		
B	The lay page 2		1 ☐ Yas	2800 1	☐ Yes 2☐ No		
ita	certificate rector, pag	25. Was case referred to medical 26. Place of Death	(Check only one)	1			
>		axaminer? 1 Yes 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residenc	ce 6 ☐Other (Spec	ity)		
ion o	Attending Physic death. octor: After this by the funeral di	27. Menner of Death 1 Natural 5 Panding (Month, Dey Year) 2 Accident investigation 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 8 Work? 1 Yes 2 No	28d. Describe how	injury occurred			
Division	2.00	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)				
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Wedical Certi	29a. Cartifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a medical examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a medical examinar: On the basis of my knowledge, death occurred at the time, date and place, a medical examinar.	and dua to the caused at the time, date	sa(s) and mannar as a and place, and dua	stated. to the cause(s)		
	To the comple	29b. Signature and title of certifier 29c. License number	2 05 396	Date signed (Month	Dey, Year)		
	10	30 Name and address of person who completed cause of peath (Item 23a) (Type, Print)	din I	1101	ball 3.		
	State Registrar	JUL 2 9 1999 Server B. Sports		the 10	2.10.0		

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Certard Auger Father P.O. Box 427		Gerard A	Auger					M	larion	Green			
Certard Auger Father P.O. Box 427 Invising ton Mary 1 and 64067	190	e. Informent's Neme	e/Reletionship (7	Type, Print)		19b. Meilir	ng Address (S	Street and Number	er or Rural	Route Number	r, City or Town, S	State, Zip	Code)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** JULY 4:10 Am Dorothy Ursula /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Prince George's Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, April 20, 9. Birthplace (State or Foreign Country) New York **Funeral** Months Days 1 □ M 2 🖾 F 076-14-5061 Yrs Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Director 1 Yes 2 No r 28a-f s notifies Maryland Prince George's Lanham 10e. Street end Number 10f Zip Code iner must be n 10g. Citizen of What Country? 9306 Rolling View Drive 20706 U.S.A. by Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry PG County Public Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker School System 17. Fether'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Pages 1 and 2 should be tent of Health and Mental Hilbert Schlieter Ursula Varno 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if them 27 is or other tra Judith A. Granados - Daughter 8924 Stratford Court, Owings, Maryland 20736 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cemetery 07/28/99 | Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD des 20781 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) SEPSIS ~ 13 days Examiner Due to (or as a consequence of): Examiner The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequence of) physician Physician/Medical Due to (or as a consequence of) signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Manner of Death 28d. Describe how injury occurred 5 Pending Investigation 1 Netural 2 Accident 1 Yes 2 No after death Director: 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifier 1🂢 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the ceuse(s) and menner as steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M.S.Na D-17874 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) COTTAGE CITY, MD 20722 S. M. NAYAR, MD. 3717-38 NS 31. Date filed (Month, Day, Year) 32 Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

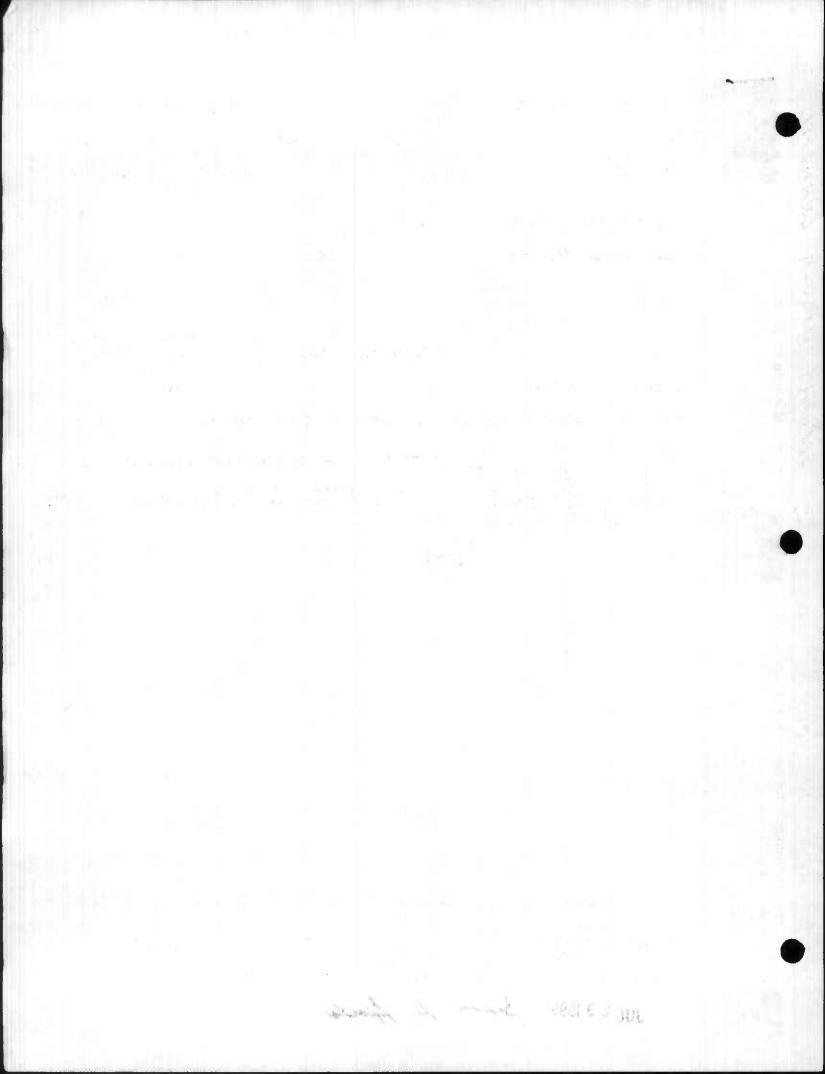
Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

She THY



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

Physician	Decedent's Name (First, Middle, La.	•	Cer	tificate of		2. Date of De	Reg. No.	3. Time of		
/Medical	Benjamin Ge		ady		4b. City, Town, or L	July ocation of Death		99 9:45	AM	
Examiner Funeral Director	Doctors Commun: 5. Social Security Number 6. S 579–28–0366	ity Hospital	yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	Lanham	8. Date of Bird	Princ	e George's 9. Birthplace (State of Country) Maryland	r Foreign	
show show	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	eation				10d. Inside Cit	ty Limits	
or 28e-1 shorter	Maryland Prince G	eorge's		Во	wie			1 ☑ Yes	2 No	
with the Me a or 28a-1 be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of V			
5-0020 72 hours after death with the Maryland natural; or thems 23e or 28e-f show sicel Exeminer must be notified at sted by Funeral Director	13029 6th St. 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 P No If Yes, Give X Year or Dates:	If		20720 dispanic Origin? (Sp an, Mexican, Puerto Specity:		United S 14. Race Blace Specify	e - American Indian, k, White, etc.		
T = 1 = 3	15. Decedent's Ed (Specify only highest gra Elementary/Şecondary (0-12)	lucation	(Give A	ent's Usual Occup ind of work done O NOT use retired ockey	pation during most of work d)	sing	16b. Kind of Bu	White siness/Industry	stry	
Be Cothy	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumam	0)		
laryla 2 should and Men a marke aumatic	John E. Brady 19a. Informant's Name/Reletionship (Type, Print)	19b, Mailine	Address (Street	and Number or Rui	Woods	er, City or Town,	Stete, Zip Code)		
Maith a saith a ser trau	Alice Brady/wife	4	1302	9 6th St	. Bowie,	MD 20	720			
THORE 1 ages 1 and of Heart Hill Heart you oth	20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control	Removel from State		atory or other place	1	Date 7 / 26 / 9		City or Town, State		
Baltmore, M permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other training.	21. Signature of Funeral Service Licen		22. R	Name and Addre obert E.	ge Memorial Park 7/26/99 Elkridge, MD ame and Address of Facility bert E. Evans Funeral Home, Inc. 000 Annapolis Road Bowie, MD 20715					
	23a. Part1. Enter the disease, or com shock, or heert failure. List only	plications that caused the one cause on each line.						Approximate Intervel Betwoen and D	ween	
Physician /Medical Examiner	Immediete Cause (Final disease or condition resulting in death)	e. End St	age Po		hic Can	a' no m	4	2-3 4		
68760, Itesta be associted physician and is the burlai-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	to (or as a consequence to (or as a consequence)							
	leading in death) Last	d								
P.O. BOX (at the death certified by the ettending etsched for use a Physician/M.	Part II. Other significant conditions or	ontributing to death but no	t resulting in the un	derlying cause giv	ven in Part t.	23b. Did	tobacco use cor	tribute to the cause o	of death?	
						10	Yes 2□ No	3 Probably 4 4	Enknown	
aw requir as been s 2 should							an autopsy rmed?	24b. Were autopsy fi available prior to completion of co of death?	indings o ause	
						10	Yes 2000	1 ☐ Yes 2 ☐	110	
Of Vital Physicien: The Physicien: The serificate rai director, page TO Be CO:	25. Was case referred to medical examiner?	Hospital:	-5	Oth Oth	26. Placa of Deel					
Vision of Attending Physical Attention of Control of Co	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	28c. Injur	4 LI Nursing Ho	1100	dence 6 □Othe how injury occurr			
Division of the Hospital or Attending Ph. Within 24 hours after death. To the Funeral Director: After th completally filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, stre	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				ber,	
DIV To the Hospital or / Within 24 hours after To the Funeral Dire completaly filled in b	29e. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exa and manner stated.	knowledge, deeth minetion and/or inve	occurred et the tirestigation, in my o	me, date end place, ppinion, death occur	end due to the red at the time,	cause(s) and ma date and pleca, a	nner as stated. and due to the cause(s))	
To the To the company	29b. Signature and title of certifier	angolute.	w. b.	29c. Licens	e number . 20905		29d. Date signed	(Month, Day, Year)		
(8)	30. Name and address of person who	2007.0		Print)	ox lone	Bour			-	
State Registrar	31. Date filed (Moeth, 891399)	32. Registrar's S								

State of Maryland / Department of Health and Mental Hygiene 3 9 2536

				Ce	rtificat	e of	Death		F	Reg. No.			
	1. Decedent'a Nama (First, Middle	s, Last)							2. Dete of Dee		Vana	3. Time	of Death
Physician	MARGERY	Ρ.	BARNETT						Month July	20,	Year 1999	3:0	2 PM
/Medical Examiner	4a Facility Name (If not institution						4b. City, To	wn, or Lo	cation of Deeth		ty of Death	3.0.	
LAGIIIIICI	2709 Shawn Cou	irt					Fort	Wash	ington	Prin	ce Ge	orges	
Funeral	5. Sociel Security Number		Age (In yrs. las	t birthday)	If Under		If Under	24 Hrs.	8. Date of Birth (Month, Day			place (State	or Foreig
irector	578-38-3027	1□ M 2□XF	6	9 Yrs.	Months	Deys	Hours	Min.	Aug. 17				
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18	10a. State 10b. County		10c. City, 7	Town or L	ocation							10d. Inside	City Limi
edical Examination must be purified at	MD Prince	Georges	Fort	Wash	ingto	n						1 (<u>X</u> (Ye	s 2 N
Director	10e. Street and Number				10f. Zig	Code				10g. Citizen of	Whet Cou	ntry?	
4 0	2709. Shawn Cour	. +					20744			U.S	Λ		
era		12. Was Decede	ent Ever in 11 S	13	Was Dece	dent of I			ocity Yes or No-		• A •	can Indian.	
Funeral	11. Marital Status 1 Nevar Marriad 2 Marr	Armed Force	es?	10.	If Yas, spe	city Cub	en, Mexicar	, Puerto	ecify Yes or No- Rican, etc.)	BI	eck, White,		
by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give			1 🗆 Yes	2 X No	Specify:			Spec	ity: Bla	ck	
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Completed	15. Deceden (Specify only higher			(Give	dent's Usu kind of wo	rk done	during mos	t of worki	ing	16b. Kind of	business/ir	idustry	
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	19a, Informant's Neme/Relations								al Route Numbe			p Code)	
ouce.	Julia A. Mitche	ell - Daugh	nter	2709	Shaw	n Ct	t., Fo	rt W	ashingt	on MD	20744		
	20e. Method of Disposition		cam	e of Disp	osition (Na	me of	re)		Data	20c. Location	- City or T	own, State	
	1 Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ete		coln				-23-99	Brantw	boo	MD	
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900	La Company Com	2001	1	-	Mars	hal	l's Fu	inera	1 Home,	Inc.			
	1 X P. 10	Josephall							d, Suit		Mary1	and	2074
	23a. var . Enter the diseese, or	complications that cau	sed the death.	Do not en	iter the mod	de of dy	ing, such as	cardiac c	or respiratory ar	rrest,	1	Approxim Intervat B	ele
ong physician and se as the buriel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in daeth) Lest	c. Conges	Stive He	eart	Failu	ıre					-		
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Completed									perio		C	ompletion of death?	f cause
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00	25. Was case referred to medica examiner?	Hospitel:				. 0	her:		h (Check only o				
70	1 Yes 2 No	1 LIND		VOutpatie		UA	4 LI NI		me 5 Described	275		ity)	
Certification:	27. Manner of Deeth 1 DNaturat 5 □ Pendin		Day Year)	Bb. Time of Injury		28c. Inju			28d. Describe i	now injury occ	urred		
cat	2 Accident Investig				М	1	Yes 2						
Ě	3 Suicide 6 Could determ	ined 200. Placa of	Injury - At home, etc. (Specify)	e, ferm, st	treet, factor	y, office)		28f. Location (S City or Tox		nber or Ru	ral Route N	um <i>ber</i> ,
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edical		g Physician: To the be Examiner: On the basi	is of examination										e(s)
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tate	31. Dete tiled (Month, Day, Year)		pistrar's Signetur						202 041				
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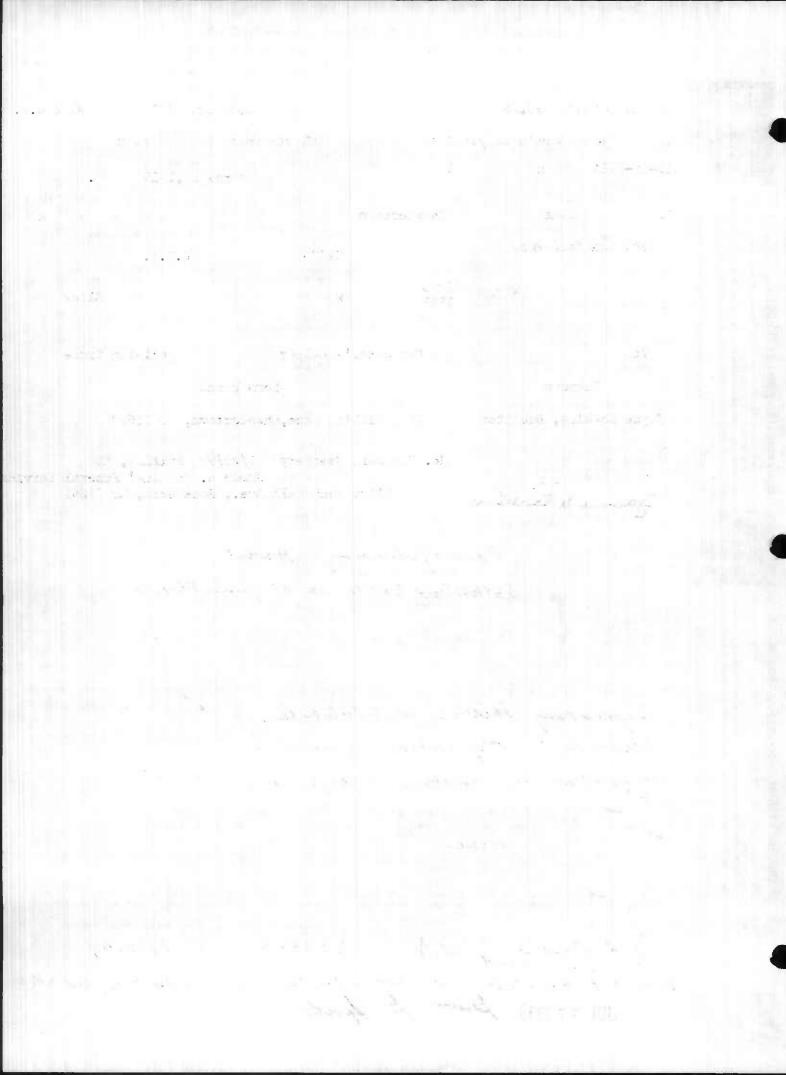
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State of Maryland / Department of Health and Mental Hygiene 99 25362

						Cer	rtificat	e of	Death			Reg. No.	-		
		1. Decedent's N	lame (First, Middle, L	est)							2. Data of De		Maria	3. Time of	Death
	Physician	Harrie	son Miffin	Black							Month Tuly 22	Day 1999	Year	0400	p.m.
	/Medical Examiner		e (If not institution, gi		ber)				4b. City, To		cation of Deal		of Death	3,100	Реше
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		Usual Residence	e of Decedent								March_	21,1919	M	d.	
Jene	8 m	10a. State	10b. County		10c. City, To	own or Lo	cation						1	IOd. inside Cl	ty Limits
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5	28a	10e. Street and	Number				10f. Zip	Code				10g. Citizen of V	Whet Cour	ntry?	
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21215-0020 d within 72 hours af	- 4	(S	econdery (0-12)	ade completed) College (1-4	Aor 5+)	(Give	kind of wo DO NOT u	erk done se <i>retire</i>	during most d)	of work	n <i>g</i>				
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a de	nd Mental Hygiena. marked other than imatic event, the Manage To Be Comp		Unknow	n						Nora	Black				
Maryland nd 2 should be file	marked or umatic eve		s Name/Relationship	(Type, Pnint)	1	9b. Mallin	ng Address	s (Street	and Numbe	r or Run	al Routa Numi	ber, City or Town,	State, Zir.	Code)	
Z 20	Health a om 27 le other tra	Joyce	Hopkins,	Daughter	r i	7431	Wilk	ins	Lane,	Ches	tertow	n, MD 21	620		
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Di To the Hospital or	within 24 hours efter deatt To the Funeral Director: completely filled in by the Medical Certifical	-	and titla of certifier	a.io mome			29	c. Licans	sa number			29d. Date signe	d (Month,	Day, Year)	
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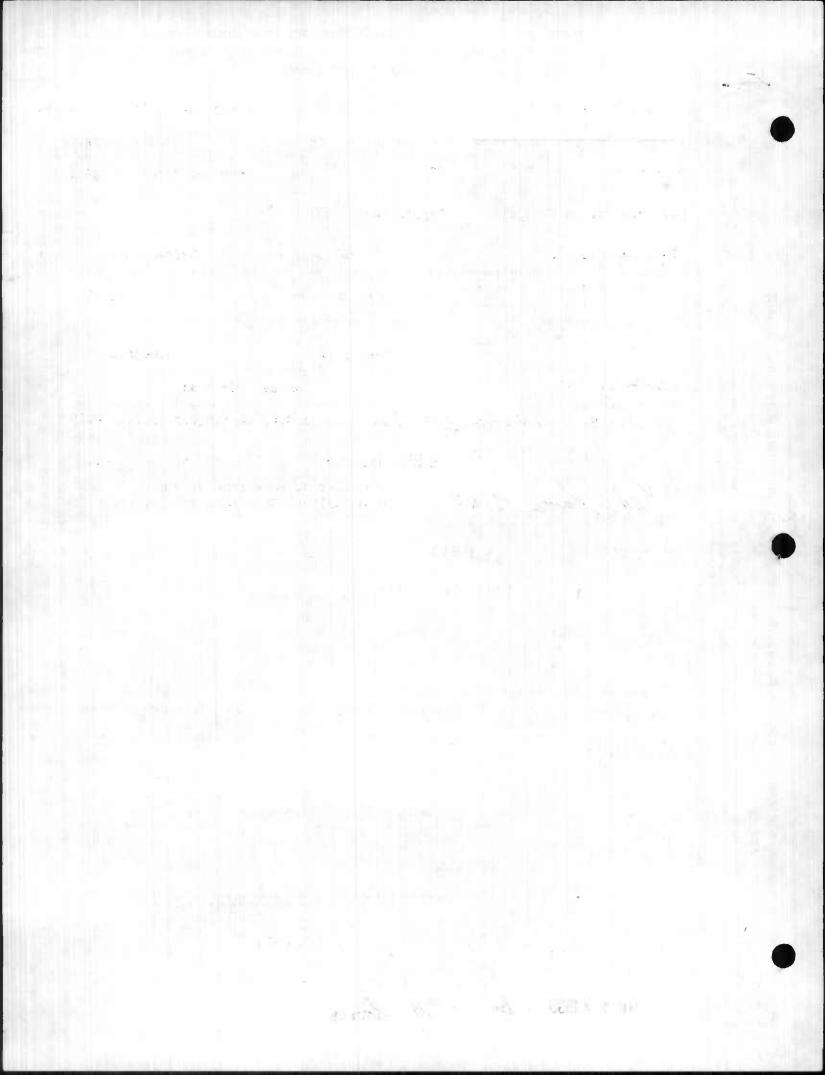
31. Date filed (Month, Day, Year)

AUG 0 4 1999

32. Registrar's Signature

118 0 1830 Jane 1886 1 18 3m

	cedent's Name (First, M		28-99 cr	7.11	20.11	ficate of		2. Dat	Reg. N e of Death oth D	ay	Year	3. Time of Death
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5. Soc	ial Security Number	8. Sex	M 2 F 7.	Age (In yrs. 8	lest birthday)	f Under 1 Year fonths Days	If Under 2	24 Hrs. 8. Dat Min. (Mo	e of Birth onth, Dey, Year 30, 1	r)		e (Stete or Foreig
Usuai 10a. S	Residence of Deceden			10c. City	/. Town or Locat	ion					10d	Inside City Limit
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10	arital Status ☐ Never Married 22 II ☐ Widowed 4 ☐ Divor	Married	2. Wes Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	s?] No	If Ye	s Decedent of les, specify Cub	ban, Mexican,	gin? (Specify Ye , Puerto Rican,	s or No- etc.)	Blac	e - American ck, White, etc :: Black	
	15. Dece	dent's Educ	ation		16a. Decedan	t's Usual Occu d of work dona	pation	all constrains	16b.	Kind of Bu	usiness/Indus	itry
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	hn Wesley								nnaday		.,	
JO 19a. I	Informant's Name/Ralat	lonship (Typ	oe, Print)		19b. Mailing	Address (Stree		or or Rurel Route	-	or Town,	Stete, Zip Co	ode)
Co	licchio Pro	octor/	Daught				cle S.	E. Wash	ington	, D.C	200)19
	Method of Disposition ☐ Burial 2 ☐ Cremati	ion 3□Re	emoval from Sta	0	lace of Disposition emetery, cremet	on (Neme of ory or other ple	ece)	Date	20c.	Location -	City or Town	, State
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District of Column Street and Number 795 Barnaby R		10c. City,		Months	1 Yeer Days	If Under 24 H Hours M		y. Year)937	9. Birthple Cougti South	aca (State or Foreign
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Never Merried 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Yeer or Dates:		If	Vas Deced Yes, spec ☐ Yes 2	cify Cuber	n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ca - America ck, White, e	tc.
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THU YES ZLINO	1 L Inpatio		ER/Outpatien		/A	er: 4 Nursing	Deeth (Check only on Home 5 ☐ Residue)	dance 6 Noth	US C.	where
Menney of Deeth Matural 5	(Month, Da	jury - At hor	Injury ma, farm, stre	M	101		28f. Location (Street and Numb		Route Number,
	nar: On the besis of	f examinetic		estigation,	in my op	inion, deeth oc	curred at the time,			
Signature end title of cartifier	tudo			290	C. License	number Fo Y		29d. Date signe	ed (Month, C	Pay, Year)
	Father's Name (First, Middle, Last) Lazarus Bryant Informant's Name/Relationship (T. Sylvia B. Moten Method of Disposition 1	Lazarus Bryant Informant's Name/Relationship (Type, Print) Sylvia B. Moten - Daughte Method of Disposition 1	rementery/Secondery (0-12) Father's Neme (First, Middle, Lest) Lazarus Bryant Informant's Name/Relationship (Type, Print) Sylvia B. Moten - Daughter Method of Disposition Method	Sementery Secondery (0-12) College (1-4or 5+) F1	Sylvia B. Moten - Daughter 1248 Bar 12	Sementery Secondery (0-12) College (1-4or 5+)	Inferentery Secondary (0-12) College (1-4or 5+) Iffe. DO NOT use ratified)	Second content Seco	Self Floorman Mechanic Self Floorman Mechanic Self Floorman Mechanic Self Floorman Mechanic Self Floorman Mechanic Self Floorman Mechanic Self Floorman Mechanic Self Floorman Mechanic Self Floorman Mechanic Self Trudy Bradshaw Informant's Name/Reletionship (Type, Print) Is. Molhar's Name (First, Middle, Maiden Surnan Trudy Bradshaw Trudy Bradshaw Informant's Name/Reletionship (Type, Print) Is. Molhar's Name (First, Middle, Maiden Surnan Trudy Bradshaw Informant's Name/Reletionship (Type, Print) Is. Molhar's Name (First, Middle, Maiden Surnan Mechanic Self Secondary (0-12) College (1-4or 5-) Floorman Mechanic Self Emplo	

State of Maryland / Department of Health and Mental Hygiene

			Otato of III		Certificate	of Death	···o·ikai i iy	Reg. No.	25366
Dhunk	alau.	1. Decedent's Name (First, Middle, Las	st)				2. Dete of De	eth Dey	3. Tima of Death
Physic /Med		MICHAEL		BELC	HER		7		99 9:34 A
Exam		4a Facility Name (If not Institution, give)		4b. City, Town, or			
		LAUREL REC				LAURE			CE GEORGES
Funera Directo		5. Social Security Number 6. S 320-48-0961	ex 7.Ag	ge (In yrs. last birl 45	Months D	eer If Under 24 Hrs eys Hours Min.	8. Deta of Bir (Month, De 9 - 26		9. Birthplaca (Stata or Foraign Country) Logan W. Va
bud #		10a. Stata 10b. County		10c. City, Town	or Location				10d. Insida City Limits
e Mary	Director	Ky Floyd	1		Haro	ld			1 ☐ Yes 🎎 ĀNo
20 after death with the Maryler or items 23s or 28s-f show miner mast be notified at		10e. Street and Number Ky Rt 3379 Box				41635			SA
21215-0020 d within 72 hours after death with the Maryland siene. r than "natural", or tlems 23s or 28s-f show the Mariles Examiner must be notified at	by Funeral	11. Marital Status 1 X Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedant Armad Forces' 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Detes:		13. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Maxican, Puerl No Specify:	pecify Yes or No o Rican, atc.)	Specify	a - American Indian, ck, White, etc. White
72 hours	Completed	15. Decedent's Ed (Specify only highest gra	lucetion de completed)	18e.	Decedent's Usual O	ccupation one during most of wo stired)	rking	16b. Kind of Be	usiness/industry
within ene.	mple	Elementary/Secondary (0-12)	College (1-4or					Fac	tory
		9th		I	factory !		no (Cine Middle		
Maryland d 2 should be file th end Mental Hy 7 is marked oth treumetic event	o Be	17. Fether's Neme (First, Middle, Last)	George	Belcher		18. Mother's Net		Maiden Suman McKin	
Shoul Md Md Mmerit	To	19e. Informant's Neme/Reletionship (Type, Print)	196	Malling Address (S	reet and Number or Re	ural Route Numb	er, City or Town,	State, Zip Code)
		Lassie Belcher	(Mother)	F	Ty RT 33	79 Box 60	68 Har	old Ky	41635
Baltimore, bernit. Pages 1 ar Department of Hea mportant: if Item:	H	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Specification 2)		20b. Place of cemetar Davic	Disposition (Name of cramatory or other Son Memo	of place) Orial	Date 7-27-9	20c. Location - 9 Ivel	City or Town, State
Baltin pemit. Pa Departmen Important: any Injury		21. Signature of Fugural Service Licen	2 -	1	22. Nama and A	ddrass of Facility			
De de de de de de de de de de de de de de		· / My	Y /// 1	ren/		lson & Fr			
_		23a Parti. Enter the disease, or companies, or head failure. List only	oligations that cause	d the death. Do r	not enter the mode of	609 Marti	or respiratory a	rrest,	Approximate
Physician		shock of hear failure. Lisyonly	one cause on each I	ine.					Interval Between Onset and Deeth
/Medical		Immediate Cause (Final disease or condition	M	1/	0.1	Tolan	T		16-
Examine		resulting In deeth)	a	Due to (or es a	consequence of):	- Topic	Color)	
P #	Iner		Ante	rio sc	les tic	Infor	Dise	021	1 year
and -trans	Examiner	Sequentially list conditions,	0. 7. 7. 7.	Due to (or es a o	consequence of):				
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68 / 60, ficate be executed physician and as the bural-transit	edical	thet Initiated events resulting in deeth) Last		Dua to (or as e o	onsequence of):				
5 0 6			d						
death cert death cert e attendin ed for use	clar								
d by the detached	Physician/W	Pert II. Other eignificant conditions of		out not resulting in	the underlying ceus	e given in Part I.			ntribute to the cause of death? 3 Probably 4 Unknow
s that the ned by the e detach	y P	Hyperten	sien					100 2010	O Probably VACINION
HECOIGS, P.O. BOX he law requires that the death cer e has been signed by the attendin age 2 should be detached for use	Completed by						24a. Wes	en eutopsy ormed?	24b. Were autopsy findings available prior to completion of ceuse of death?
VITAL KE	mo						10	Yes 2XNo	1 ☐ Yes 25 No
VICIAN: TI Certificat rector, pa	Be C	25. Was cese referred to medical				26. Plece of De	ath (Check only	one)	
Of VITA Physician: this certifical ral director,	0	examiner?	Hospital: 1 Inpati	ent 2 ER/Ou	tpatient 3 DOA	Other:		idence 6 □Oth	ner (Specify)
	- : ·	27. Manner of Death	28a. Date of Inju	ury 28b. 7	ime of 28c.	Injury at Work?	28d. Describe	how injury occur	red
Attanding F r death. actor: After by the funer	atio	1 Selatural 5 Panding investigation		.,	M	1 Yes 2 No			
DIVISION or Attanding efter death. Diractor: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28a. Place of in	jury - At home, fa tc. (Specify)	rm, street, factory, of	fice		(Street and Numl wn, Stata)	ber or Rural Route Number,
led in the lead in									
DIVISION O The Hospital or Attanding Ph In 24 hours after death. The Funeral Director: After th mpletely filled in by the funeral	edicai			of exemination en		na tima, data and place my opinion, deeth occu			anner as stated. and due to the cause(s)
fo the	Mec	29b. Signature and title of cartifier	and menner s	iaiou.	29c. Li	cense number		29d. Dete şigne	d (Month, Day, Year)
7.59		1/ 1/	12			22966		7/-	199
		30. Neme and address of person who	completed cause	death (item 22a)	1	00100		7/25	177
0		THOMAS RIANCE	AL FOE C	20211 (Herri 208) (BLIONAL	HOLLIT	AL IA	WARFI MD
S	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature			101/1/1	1 01	
· Regis		JUL 2 6 1999	Spore	ve p	. soon	(2)			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month Dav Year **Physician** Adrienne Annette Ballute 24 1999 July 5:00 A.M. /Medical 4a Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel H Linder 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) **Funeral** Devs Hours Min. Months 1 M SEXF Director 579 42 4152 65 Nov. 18,1933 Washington D.C. Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location r 28s-f show anotified at show 10d. Inside City Limits XX Yas 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? flerns 23a or munt be 858 Yardarm Way 21401 Funeral United States 14. Raca - American Indien, Bleck, Whita, etc. 11 Maritel Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yas & No If Yes, Give Yaar or Datas: 1 Never Merried 2 Married 'natural', or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: à 3 Widowed 4 □ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Receptionist/Assistant Eve Doctor 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental William A. Chappelear Jessie V. Cochrane 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ä Department of Health a Important: If Item 27 Is any injury or other tra Otice. Janet Clark Daughter 2712 Verdis Lane Crofton Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) July 28, 1999 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) Cedar Hill Cemetery Suitland Maryland 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc. 21. Signetura of Funaral Sarvice Licen-16000 Annapolis Rd. Bowie Maryland 20715 23e. Part1. Enter the diseesa, or complications that caused the daath. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximeta tntervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examine Due to (or es a consequença of) Examine physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? P.0. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ The law requires 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 215 NO 1 Yes 1 Yes Division of Vital Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical 25. Was casa referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient To 1□ Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA funeral 27. Menner of Death Certification: 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signatura and litle of Pertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar THE ROPE STORE ROPES TO ANNAPORE MD 2(40)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

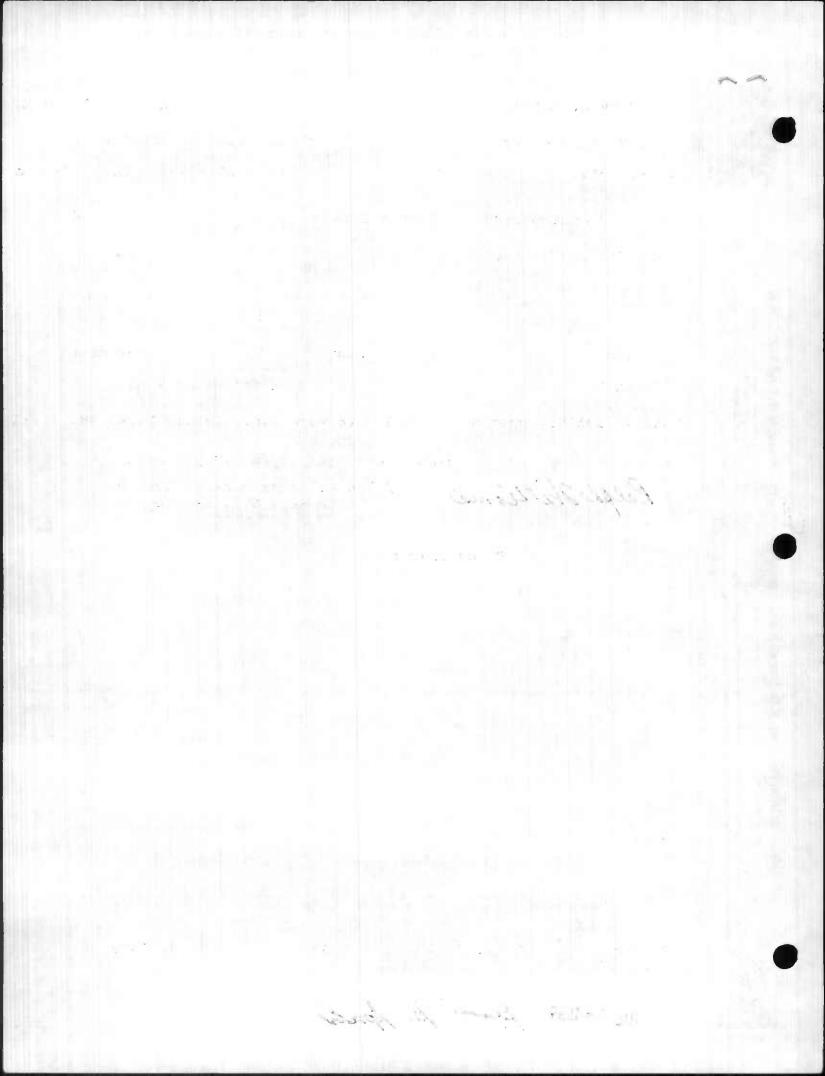
31. Date filed (Month, Day, Year)
JUL 2 8 1999

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 07 **Physician** g g Mary A. Butler 11:00 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Park Montgomery Takoma 7433 Baltimore Ave. If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 01-12-21 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10M 20x Days Hours Min Yrs Rhode Island 039-09-3456 78 Director Usuel Residence of Decedent with the Marylence r 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 N Yes 2 No Takoma Park Director MD. Montgomery 10e. Streef end Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or itama 23a or the Medical Examiner must be 20912 IISA 7433 Baltimore Ave. death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours efter c nend Mental Hygiene. Is marked other than "natural", or item 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Government 12th Clerk other traumatic avant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Madeline Haskins James N. Adams 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 Ia m any Injury or other traum DDCs. Charles Butler, Husband 7433 Baltimore Ave., Takoma Park, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rock Creek Cemetery 07-27-99 Washington. D.C. Funeral Service Licenses 22. Name and Address of Facility Ralph Williams Funeral Service Welly 517 11th St., S.E. Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 3 yrs. Colon Cancer Examiner Due to (or as a consequence of): Examiner physician and s the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be execu Box 68760, Physician/Medicai Due to (or as a consequence of): 69 USB ŏ signed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings avellable prior to Completed 24a. Was an autopsy completion of cause of death? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete or Attanding Physician: 25. Was case referred to medical examiner? Be 28. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours Hospital 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) un 7-27-99 D18219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN STAAL, M.D. 1221 MERCANTILE LANE, LARGO MARYLAND 3 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 8 1999

Registrar

JUL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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uneral	5. Sociel Security Num	N N	Sex 7. A	Age (In yrs. las		Under 1 Yeer onths Days		8. Date of Bir (Month, Da	h y, Year)	9. Birthpli Count	ace (Stete or Foreign
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t u		0b. County		10c. City, 1	Town or Location	on .				10	Od. Inside City Limits
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be notified Directo	10e. Street and Number				10	0f. Zip Code			10g. Citizen of	What Count	ry?
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State of Manyland / Department of Health and Mental Hygiene

	1 December to Name (Free Added Land		Certificate				Reg. No.	2	5370
Physician /Medical	Decedent'a Name (First, Middle, Last) NORMAN A.					Month JULY	26, 1	Year 999	1:45PM
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	HOLY CROSS HOSP I 5. Social Security Number 6. Sex		est hirthday] If Under	Year	Silver			gomer	9
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5-0020 72 hours after death with the Marylar natural; or fleme 23e or 28e-f show size Examiner must be notified at steed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	II Yes 2	fy Cub	dispanto Origin? (Si an, Mexican, Puert Specify:	Bican, etc.)		k, White,	etc.
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21215-0 ed within 72 ho yglere. we than 'nature t, the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	tife. DO NOT use	e retire	d)				
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Maryland 21215-0020 od 2 should be lited within 72 hours all the and Mental Hygiens. 77 is merited other than "restures", or traumatic event, the Medical Exam To Be Completed by F	17. Father's Name (First, Middle, Last) George Brown				18. Mother's Nan	Availabl		10)	
2 sho	19a. Informant's Name/Reletionship (Typ		19b. Meiling Address	(Street	end Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)
	Lottie M. Brown/Wi		3728 Swann		oad, Suit	7			
Pages 1 tent of H nt: If its ny or of	20a. Method of Disposition 1 Burial 2 Cremation 3 Re	00	ace of Disposition (Nemmetery, cremetory or of	e or her pla	ce)	Date	20c. Location -	City or To	wn, State
L Pa timent lary	4 ☐ Donation 5 ☐ Other (Specify)	Mar	yland Natio			7/31/99	Laurel	, Md.	
Baltimore, pomit. Pages 1 at Department of Hea Important: if Item any injury or othe	21. Signature of Funeral Service License	D. Hackett X	A. 814-	Ups	s Funera	et. N.W.			
	23a Part1. Enter the disease, or complice that the complex part failure. List only on	eations that caused the death. e cause on each line.	. Do not enter the mode	of dyir	ng, such as cardiac	or respiratory a	rreat,	1	Approximate Intervat Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting In death) a		Infarction as a consequenca of):	1				1	2 days
<u> </u>		200 10 (01	as a consequenca or).						
68760, ficate be executed sphysician and ss the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or	as a consequence of):					8	
	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or	as a consequence of);						
BOX auth cert for use	d.							1	
of to str.	Part II. Other significant conditions cont	ributing to death but not resul	Iting in the underlying ca	use giv	ven in Part I.	23b. Dld	tobacco una co	ntribute to	the cause of death?
IS, P.O. BOX set that the death cert igned by the attending be detached for use a by Physician/M	Idiopathic Pulmo	nary Fibrosis	:			10	Yaa 2□ No	3X Prol	bebly 4 Unknow
cord requir been s should	Clostridia Dific	ile Colitis					an autopsy ormed?	av.	ere autopsy findings allable prior to mpletion of cause death?
The la						10	Yes 2X No		Yes 2 No
ortifica sctor, p	25. Wes case referred to medical				26. Placa of Dea	th (Check only	one)		
Nyalch hyalch his cer il direc	examiner? 1 ☐ Yes 2 ☐ XNo	ospital: 1 💢 Inpatient 2 🗆 E	ER/Outpatient 3 DO	A Oth	or.		denca 6 □Oth	er (Specif	y)
oding Ph ith.: After the funeral	27. Manner of Death 1) Notural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of trijury M	Sc. Injui Wor	ryat rk? Yes 2 □ No	28d. Describe	how injury occur	red	
DIVISION OF VITAL HER TO the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	3 Suicide 6 Could not be determined	28e. Placa of Injury - At hor building, etc. (Specify)	me, larm, street, factory,	office		28f. Location (City or To	Street and Numb wn, Stete)	per of Rura	il Route Number,
n 24 hours n 24 hours ne Funera pletely fills edical	29a. Certifier (Check only one)	clan: To the best of my know er: On the basis of examination and manner stated.	rledge, deeth occurred a on and/or investigation,	t the tir	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	anner as si and due to	tated. the cause(s)
To the comp	29b. Signature and title of certifier		29c.	Licens	se number		29d. Date signe	d (Month,	Day, Year)
(1 Roy/me	oil MO	D	34	5 90		July 2	6 1	999
(2)	30. Name and address of person who cor		OOst (True Dales)			vs MD			
State	31. Date filed (Month, Day, Year)	Registrar'a Signatu	ure	- 1 9	, , , , , ,	1	- //		

DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene

							Cen	tificate o	f Death			Reg. No.	-23	5371
	Physician	1		e (First, Middle, L a Agnes	ası) S Harsh (Calcam _]	p				2. Date of Dea Menth	oth 64	ğg	3. Time of Death 11:00a
	/Medica Examine	An En			ive street end number ounty Mer		Hos	p.	Oak:	Land	ation of Death	Garr		
	Funeral Director	23	al Security N	9478	Sex 7. A	nge (In yrs. lest l	birthday) Yrs.	If Under 1 Yes Months Day	ar If Under rs Hours	Min.	8. Date of Birt (Month, Day 0 - 23 - 1	904	Cour	sesnoe Ru
	2	Usual 10a. S	Residenca o	f Decedent 10b. County		10c. City, To	wn or Loc	eation					1	WV 0d. inside City Limits
	d b			Presto	an .			e Run						XXves 2 □ No
	or 28a-fa	10e. S	treet and Nu	mber		1101 5	00110	10f. Zip Code	•		•	10g. Citizen of V	What Cour	itry?
	With Sa of 1		Rt.	1, Box	250			2	26769			USA		
Maryland 21215-0020	n /z hours eller death with the Marylend *natural*, or items 23e or 28e-f show edital Expirite must be nutified at	3 [13	ied 2 Married	12. Was Deceden Armed Forces 1 Yes XI If Yes, Give Year or Detes	i? &No		/as Decedent o Yes, specify Co			cify Yes or No- lican, etc.)	Biad	a - Americk, White,	
9	a material		/Sno	15. Decedent's		16		ent's Usuai Occ and of work dor		et of workin	0	16b. Kind of B	usiness/in	dustry
2	e • 20 - 4	Eler		ondary (0-12)	Coilege (1-4o	r 5+)	life. D	O NOT use ref	ired)	N OF WORKIN	9	O T	Ta	
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anc	Mentel H	1/. Fa		(First, Middle, Las	en Harsh							Meiden Suman		
2	and Mentel I marked of umatic eve			ame/Relationship		44	Ob Mailin	a Address /Ctr				ell Har		Code
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altimore,	permit. Pages 1 en Department of Heeli Important: If Item 2 any Injury or other ance.			☐ Cremation 3 5 ☐ Other (Spec	Removal from Stat	0		t Ceme		8.	/3/99	Horse	Sho	oe Run, W
	ortan ortan Injur	-	-0	megal Service Lic		ACC.		Name and Add					5 5110	Je Kull, W
ä	Department of the partment of		VI.	VOON	that b								`	
		23a. F	art1. Enter t	he disease, or co	mplications that caus	ed the death. D		O Box				26260 rest,	,	Approximate
Į,	hysician		hock, or hea	in failure. List on	y one cause on each	line.							1	interval Between Onset and Death
	/Medical	Imme	diate Cause	(Finai	Amak	e renal	£ - 1 1						1	11-
	Examiner	resulti	ng in death)		a. Acut	Due to (or as		1-1-1-1						l_week
	o = .5				. Hype	rtension	n							40 years
	physician and sthe burial-transit	Seque	ntially list co	inditions,	0	Due to (or as		uence of):						
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68760,	FT FTD 600	resulti	itiated events ng In death)	S		Due to (or as	a consequ	ience of):					†	
Вох	eath cent ettending for use a				d									
	0 0 0 0	Part II.	Other etgnif	ficant conditions	contributing to death	but not resulting	in the un	derlying cause	given In Part	I.	23b. Dtd 1	tobacco use co	ntribute to	o the cause of death?
o i	by th										10	Y00 2000	3 Pro	bably 4 Unknow
Ś	es mat igned b	Ri	ght Hi	p Fracti	ire, Systo	lic hear	rt fa	ilure			-	-	T	
Vital Record	pege 2 should be	2									24a, Was perfo	an autopsy rmed?	av	ere autopsy findings aliable prior to empletion of cause
ပို	hes be												of	death?
r	pege pege	5									101	res 2 No	1[☐ Yes 2☐ No
<u> </u>	s certificete director, peg	25. W	as case refer	red to medicai						e of Death	(Check only o	one)		
5	this certific ral director.	10	Yes 💫	·	Hospitai:		Outpatient	3LI DOA				denca 8 🗆 Oth		y)
	After the funeral fune	27. Ma	nner of Deat	h 5 Pending	28a. Dete of In (Month, E	jury Jey Year) 28b	Time of tnjury	28c. Ir			8d. Describe I	how injury occur	red	
Sio	r death. ector: After by the fune	2[Accident Sulcide	Investigati	ho				Yes 2		Of Location (Street and Numi	har or Pun	el Route Number,
	In the death, If Director: After the funeral of the	41	Homicide	determine	d 28e. Place of I	njury - At home, etc. (Specify)	tarm, stre	et, factory, offic	za	-	City or Tov		Jei Oi Nuit	ii Nobie Walitzer,
/	Ed hou		Certifier Check only one)	for Certifying F	Physicien: To the bes aminer: On the basis and menner:	of examination a	lge, death and/or inv	occurred at the estigation, in m	time, date e y opinion, de	nd placa, a ath occurre	nd due to the	cause(s) and made and place,	anner as a end due t	itated. the cause(s)
(L L L			I title of certifier		7		29c. Lice	ense number			29d. Date signe	d (Month,	Day, Year)
1	0	1	Mia	engal.	it de	11	.0	7.	26650			2/2/00		
1		30 No	me and add	ress olippreon wh	o completed cause of	death (Item 22	a) (Tune F		26650		18	3/2/99		
1),				ser, M.D.	PO Box			nd, MD	2155	0			
	State	21 De		th, Dey, Year)		trar's Signature					_			
	Registra			AUG 12		eneva	B.	doo	del					

A MICH. BALLINGS STREET, TO SOLL MAT AND AND AND - forest waters beat a

			State of Mar		tificate of			Reg. No.	25.72	
а	Physician	1. Decedent's Nama (First, Middla, L	ast)				2. Data of De Month		3. Tima of Dea	ath
	Physician /Medical	Ronald David C	reamer					1, 1999	3:45 AN	М
	Examiner	4a Facility Nama (If not Institution, g	ve street and number)			4b. City, Town, or Lo	ocation of Deat	h 4c. County of	Death	
1		1392 Theodore Ro	ad			Port Depo	sit	Cecil		
	Funeral	Social Security Number 6.		In yrs. last birthday)	If Under 1 Year Months Days		8. Data of Bir (Month, De	rth year) 9	. Birthplace (State or Fo Country)	raign
L	Director	212-48-6011 Usual Residence of Decedent	1⊠M 2□F	54 Yrs.	Monaria Days		ember 6		laryland	
	72 hours after death with the Manyland natural; or Items 23s or 28s-1 show the Examples must be notified at sted by Funeral Director	10a. Stata 10b. County	1	Oc. City, Town or Lo	cation				10d. Insida City Li 1 ☐ Yes 2 ⑤	
	or 28a-f s	Maryland Cecil		Port Depos				40- 02	*	*
	di vid				10f. Zip Code		M. Cal	10g. Citizen of Wha	it Country?	
	r hems 23	1392 Theodore Ro			21904			United St		
	Pr de	11. Meritel Stetus	12. Was Decedent Ev Armed Forces?	er in U,S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yas or No Rican, atc.)		Amarican Indian, White, etc.	
20	or aff. or by F		1 ☐ Yes 2 ☒ No	1	☐Yes 210 No	Specify:		Specify: _	71	
8	natural,	3 Widowed 4 Divorced	Year or Dates:						Thite	
21215-0020	ed within 72 hor ygiene. or than "natura ft, the Woolest	15. Decedent's E (Specify only highest g	ade completed)	16a. Deced	ent's Usual Occup kind of work done	pation during most of work id)	ing	16b. Kind of Busin	,	
12	within ene.	Elementary/Secondary (0-12)	College (1-4or 5+)			0)		owner/ope		
7	filed within Hygiene. Wher than ant, the M	12 17. Father's Nama (First, Middle, Las	4	Dog Tr	ainer	18 Mother's Nem	a /Firet Middle	Maiden Sumama)	ning Center	
Maryland	Mental Hyperical Mental Hyperical Mental Hyperical Mental Hyperical Mental Ment									
3	should be nd Mental marked o umarke av	TOTAL DE OZEGIA		1		Virginia				
2	O	19a. Informant's Name/Relationship						er, City or Town, Sta		
6	f Health Ham 27 I	Lynn P. Creamer	/ Spouse	20b. Place of Dispos		Road, Po			land 21904	
0	8 5 2 0	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3	Removal from Stata	cemetery, cren	natory or other pla	(ce)	Data August	20c. Location - Cit	y or rown, State	
Ë	men men men men men men men men men men	4 ☐ Donation 5 ☐ Other (Spec	(v) Nort	h East Me	thodist (Cemetery 4	, 1999	North Eas	t, Maryland	d
Baltimore,	permit. Page Department of Important: If any injury or price.	21. Signature OF uneral Service Line	Asses /	22. C.r.	Nama and Addre	ess of Facility neral Home				
ш	20729	1/1/2/201/1/1	mich					rth Fact N	Maryland 21	901
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused th	e death. Do not ente	or the mode of dyi	ng, such as cerdiac	or respiratory a	rrest,	Approximate	
	Physician	SHOOK, OF Heart lander. List Offi	One cause on addrime.						Onset and Deat	
	/Medical	Immediata Cause (Final disaasa or condition	Mer	STATIC	1	· Co.				
	Examiner	rasulting in death)		e to (or as a consequence		,				
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	physician and s the burist-transit	Sequentially list conditions	b	e to (or as a consequ	uence of):					
ó	EX Par	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		A STATE OF THE STA						
68760,	physicia the bur	that initiated events	C. Du	e to (or as a consequ	ience off:					
-		resulting in death) Last								
Box	eath certific attending p of for use as iclan/Me		d							
Ď	death e atten ed for u	Det II Other significant conditions	and the disc to death had a	and an audition to the or	A. A. I		non Did	Anhanadium anned	bute to the cause of de	
0	the the the	Part II. Other significant conditions	contributing to death but i	not resulting in the un	ideniying cause gr	ven at Part I.				
0	5 60						112	Yea 2□No 3	☐ Probably 4 ☐ Unk	inown
ds,	een signe hould be d						24a. Was	an sutopsy 2	24b. Wara autopsy findir	ngs
ecord								ormed?	available prior to completion of cause	0
Re	has t								of death?	
	cate her. Page						10	Yes 20-No	1 ☐ Yes 2 ☐ No	
Vital	Physician: The this certificate ral director, page to Be Co	25. Was casa refarred to medicat axaminer?	Hospital:		l Ow	26. Place of Deat	h (Check only	one)		
of	T die	1 Yas 2 1 No	1 lnpatient		JU DON			idence 6 Other	(Specify)	
	After t funer funer funer funer	27. Manner of Death	28a. Data of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occurred		
Slo	Attanding r death. ector: Afte by the fune lflcatlor	2 Accident investigation			M 1	Yes 2 □ No				
Divislon	all or Attanding P rs after death. al Director: After t ed in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not detarmined		- At home, farm, stre	et, factory, office			(Street and Number wn, Stata)	or Rural Route Number,	
0	Ce de Date									
	within 24 hours a within 24 hours a Completely filled		hysician: To the best of n miner: On the basis of ax and manner state	camination and/or inv						
	within To the comple	29b. Signature and 50s of ceptiler			29c. Licens	se number		29d. Data signed (/	Month, Day, Year)	
		1 /2	7		DOOR	2205		0 0 00		
	0	20 Navierano actiones of	completed source of deat	th (Itam 22a) (Time 1	D003	2395		8-2-99		
	8	30. Name and address of person who								
	Chris	Thomas Finucan 31. Data filed (Month. Day, Year)	MD 3 Mau 32. Registrar's	Idin Ave	nue, No	orth Eas	t MD	21901		
	State Registrar	AUG 0 2 1999	Beneva	B. 1	and 1					

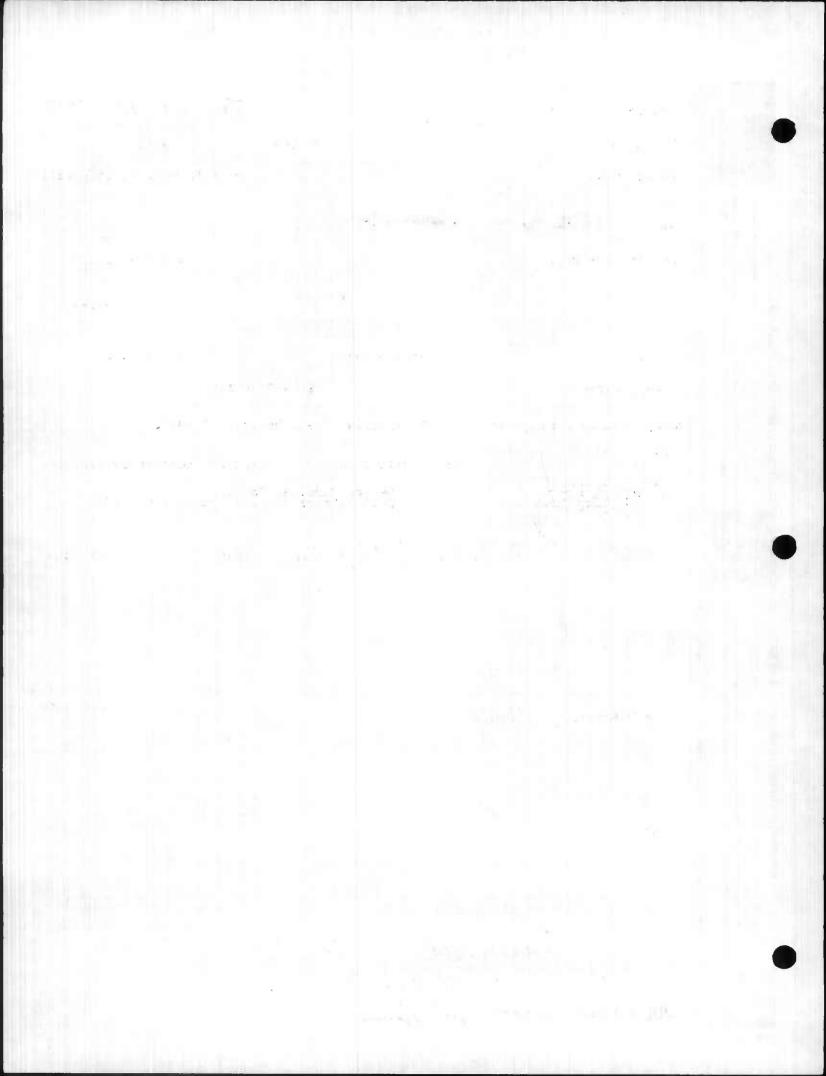
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177.72		Decedent's Name (First, Middle, Last)	Certificate o	f Death	2. Date of Dea	Reg. No.	See S	3. Time of Death
Physiciar /Medica	_	DELPHIA G. CARTER			Month 04	27	Year 9	7:2041
Examine	r	4a. Fscility Name (If not institution, give street and number) Heartland Health Care Center	- Adelphi	4b. City, Town, or Lo				Georges
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. la	st birthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day 1/1/1			lace (State or Foreigntry)
show d.at		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location				1	0d. Inside City Limit
a or 28a-f show be notified at	ector	Maryland Prince George Lar	dover					1 ☐ Yes 2 ☐ No
23a or		1101 Hill Road	10f. Zlp Code 207		1	10g. Citizen of U.S		iry?
r Itams	by runer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent o	Hispsnic Origin? (Spuban, Mexicen, Puerto o Specify:	ecify Yes or No- Ricen, etc.)	14. Rad Bla Specif	ce - Americ ck, White, y: B1a	
then "naturn the Medical I		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work dor, life. DO NOT use reti Clerk	upation e during most of work red)	ing	16b. Kind of B		dustry
工业基本		12th 17. Father's Name (First, Middle, Last)	Clerk	18. Mother's Name	e (First, Middle,			ermient
and Mental a marked o sumetic evi	0	Van Gaither			Price			
4 7 400 30	1	19e. Informent's Name/Relationship (Type, Print) Kashaka Keita, Grandson	19b. Mailing Address (Stre 11405 DunDee					
or other b		20s. Method of Disposition 20b. Pla 1 □ Purial 2 □ Cremation 3 □ Removal from State	ce of Disposition (Name of netery, crematory or other p	lace)	Date	20c. Location	- City or To	wn, State
Separtment mportant: any injury ance	-		coln Memorial	Cemetery	8/2/99	Suitla	ind, 1	Maryland
Par Land		Ruth C. Hall, CC0347		ress of Facility HERS FUNER da Avenue,			ton T	2000
attending physician and afor use as the burial-transit afor use afor use as the burial-transit afor use afo	eaicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	as s consequence of): as a consequence of):	ylumi	9			years
by the attending etached for use a	200	Psrt II. Other significant conditions contributing to death but nof resuit	ing in the underlying cause	given in Part I.	23b. Did to	obacco usa co	ntributs to	the cause of death
igned by the be detached by Physical by Ph		texpertension			10 Y	00 25CNO	3 Prot	pably 4 Unknow
as been s 2 should		ralnutréeige-			24a. Was s perfor		ava cor	ere autopsy findings allable prior to mpletion of cause death?
certificate harden page					1 🗆 Y	es 2 DNo	10	Yes 2000
r this certific	0	25. Wes case referred to medical examiner? 1 Yes 2 1 No	R/Outpatient 3 DOA	26. Place of Death	h <i>(Check</i> on <i>ly or</i> me 5□ Reside		ner (Specifi	<i>(</i>)
2 2 0	- 1	27. Menner of Death 1 Shatural 5 Pending 2 Accident investigetion 28s. Dete of Injury (Month, Day Year)	8b. Time of lnjury M 1		28d. Describe he			
		3 Suicide 4 Homicide 6 Could not be determined 28e. Placa of Injury - At hom building, etc. (Specify)	e, farm, street, fectory, offic	8	28f. Location (Si City or Town		ber or Rura	l Route Number,
The Functal Direction of the Functal Direction of the Functal Direction of the Functal Certain	2	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl considerate Examiner: On the basis of examination and manner stated.	edge, death occurred at the n and/or investigation, in my	time, date and placa, opinion, deeth occurr	and due to the cred et the time, d	ause(s) and mi lete and plece,	and due to	ated. the cause(s)
Me dompt		29b. Signature aportitle of certifier		nse number	2	9d. Date signe	d (Month, i	Day, Year)
(0)		Xlue	DI	9609.	4	7.27	- 5)
		30. Neme and address of person who completed cause of death (Item 2 Tuli Raman, MD. 3503 Perry Str		B. Mt. Rai	ner. Mai	rvland	20712	
State		31. Date filed (Month, Day, Year) 32. Registrar's Signatu		_, 1101	, , , , , , ,			

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State of Maryland / Department of Health and Mental Hygiene 9 9 9 5 3 7

December Part Models Last December Part Models Last December Part December Par			Certificate of Death	Reg. No.
ROBER R. Data T. Data		Decedent's Neme (First, Middle, Last)		
Entitline Fund in Hispotite 13 Fund in Hispotite 13 Fund in Hispotite 13 Fund in Hispotite 14 Fund in His		Reece W. Darnell		
Unition Rospite 1 Director Toronto T			4b. City, Town, or Loc	cation of Death 4c. County of Death
Social Security Number C. See 1.0 Am 7. App (in yes text browday) Trigger Types Tr		Union Hospital	Elkton	Cecil
December of December 1 10. Season of December 1 10. Season 1 10. Control of December 1 10. Control of Decembe	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. las	(birthday) If Under 1 Year If Under 24 Hrs.	
The support Continue of The	Director	239-22-0299	Yrs	
The support Continue of The	ehow		Fown or Location	
The support Continue of The	Ne Ne Ne Ne			
The support Continue of The	Viet Viet C	10e. Street and Number	10f. Zip Code	Tog. Citizen of What Country?
The support Continue of The	45 at			United States
Emergency Emer	P 2 2 2	1 Never Married 2 Married 1 Yes 2 XXI		Specify:
Emergency Emer	Do non		16a Decadent's Usual Occupation	
19 State of the st	T C 9 5	(Specify only highest grade completed)	(Give kind of work done during most of workin life. DO NOT use retired)	ng
19 State of the st	within the			
Name and Address of Parity 1998	D being			
Name and Address of Parity 1998	Marie Marie			
Name and Address of Parity 1998	Werker Market			
Name and Address of Parity 1998	Aar 2 sh and 1 mm	19a. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rure	I Route Number, City or Town, State, Zip Code)
Name and Address of Parity 1998	and and n 27			
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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Ray 6/95



Physician /Medical Examiner

physician and the burial-transit Box 68760 for use as P.O. signed by the e Division of Vital Records, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica itely filled in by the funeral director, I

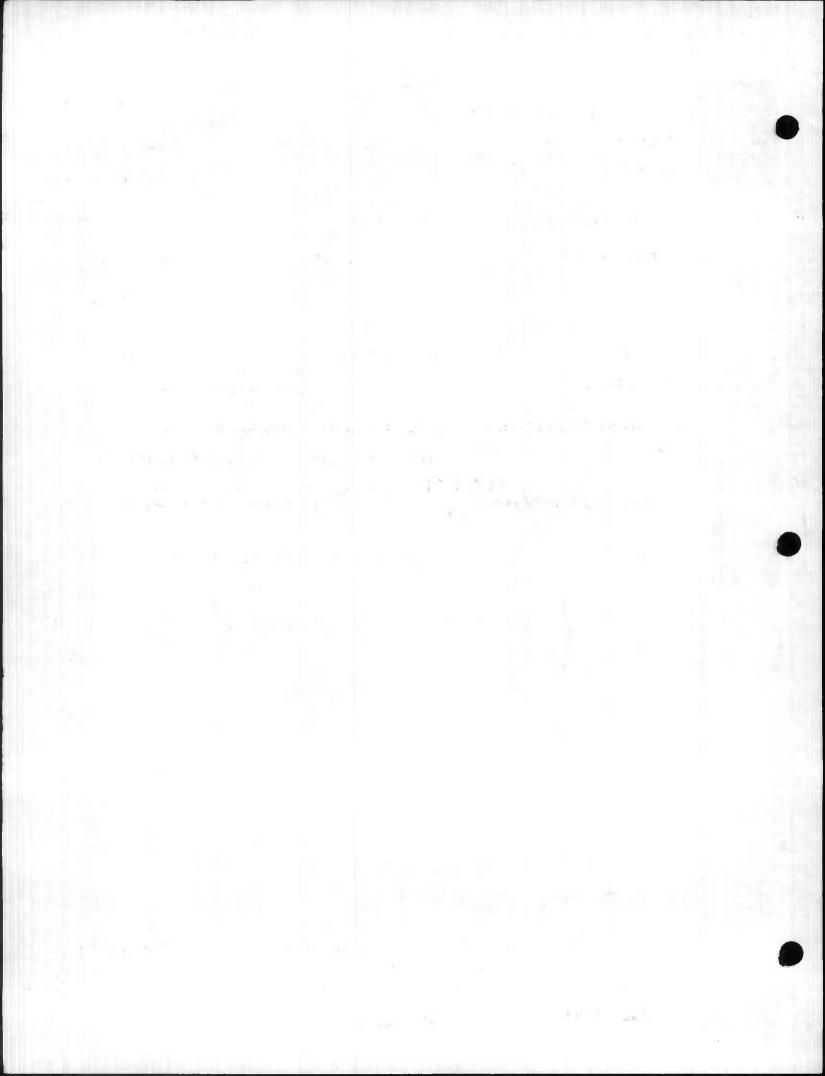
1. Decedent'a Nama (First, Middle, Last) 2. Date of Death **Physician** 4:25 N Rosa Cornelia Dubose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Lanham Prince George's # Under 1 Year | if Under 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 F 250-36-0445 Yrs. Director Sept.20, 1921 Sumter, S.C. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Prince George's 1X Yes 2 No Director Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ò items 23s 1011 Fenton Place 20774 Funeral United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Orlgin? (Specify Yes or No-tf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 Navar Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: "natural", or 1 ☐ Yes 2 ☒ No ð Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th end Mental Hygiene.
7 Is marked other than *ne Elementary/Secondary (0-12) College (1-4or 5+) Seamtress Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Frank Dubose Mary Estelle Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heelth er Important: If itam 27 is any injury or other trau 20b. Placa of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremetion 3 ☐ Removal from State Cedar Hill Cemetery 7/31/99 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvica Licensea 22. Nama and Address of Facility M 0981 Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747 in that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final diseasa or condition resulting in death) ERFORATION OF DUODENAL ULCER Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequenca of) STAGE CARDIAC Physician/Medicai Due to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ð Completed 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manger of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suictde 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Ptaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date end placa, and due to the ceuse(s) end menner es stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signatura and title of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E POINT DR. FIMPUANCIAIP MO 31. Data filad (Month, Day, Year) JUL 2 8 1999 32. Registrer's Signature State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month **Physician** 1999 195 4b. City, Town, or Location of Beath Wilda Earle Eaton /Medical County of Death 4e Fecility Neme (If not institution, give street and number 4c. Examiner George's Hyattsville 2230 Charleston lace If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗙 F 73 Yrs. 220-16-6506 March 16, Director Maryland Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 N Yes 2 No Directo Prince George's Maryland West Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 2230 Charleston Place U.S.A. death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Status Bleck, White, etc. filed within 72 hours efter Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: PV 3 ☐ Widowed 4 🖾 Divorced White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry marked other than Elementery/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator Private Industry 17. Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill timent of Haalth end Mental Hant: If item 27 la marked oth jury or other traumatic even William Earle Freeland Nellie Virginia Bucklew 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Paul A. Eaton - Son 7720 Sharewood Drive, Jessup, Maryland 20794 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If any Injury or pnce. Hillcrest Memorial Park 07/30/99 4 ☐ Donetion 5 ☐ Other (Specify) Cumberland, Maryland 22. Name end Address of Fecility 21. Signature of Funeral Service Licansee Gasch's Funeral Home, P.A. Jasck 4739 Baltimore Avenue, Hyattsville, MD 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate intervel Between Onset and Deeth **Physician** Arterioseferatic Cardiovascular Disease /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner Examiner physician and s the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) attending p 80 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1X Yss 2 No 3 Probably 4 Unknown signed b p 24b. Were autopsy findings eveileble prior to completion of cause of death? should l 24e. Wes en eutopsy performed? Completed s certificete has t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Wes case referred to medical 8 26. Place of Deeth (Check only one) 27. Menner of Deeth Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Affer 1 Neturel 5 Pending 1 Tyes 2 No death. 2 ☐ Accident investigetion Director: / 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hours aft e Funeral Di oletaly filled in Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et tha time, dete end pleca, and due to the cause(s) end menner as steted edical (Check only one) 28 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the caus (s) To the within 2 To the end menner stated. 29d. Dete signed (Month, Day, Year 29b. Signeture end title of certifier 29c. License number P11804 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 0 Drive cheverly 3001 Hospi'tal Mary land 20783 31. Dete filed (Month, Day, Year) State 3 0 1999

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Helen Lucille Langley Fox July 24, 1999 3:00 A.M 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Lanham Prince Georges Doctors Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) 1 M 2 F Nov. 19,1911 Wash. 577-38-7480 Usual Residence of Deceden 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Upper Marlboro Prince Georges Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20772 US 8900 Brookridge Drive 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 W No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Supervisor-retired 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Catherine Stamp Charles Henry Langley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1772 19a. Informent's Neme/Reletionship (Type, Print) Patricia M. Avery-dtr. 8900 Brookridge Dr., Upper Marlboro, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete Gate of Heaven Cem. 07-28-99 Silver Spring, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Beall Funeral Home 21. Signeture of Funeral Service Li M00025 Robert G. Beall 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth RESPIRATORY FAILURE Due to (or es a consequence of): CARDIAC APRHYTHMIA. Immediate Cause (Final disease or condition resulting in death) weekp Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the causs of death? 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No INSUFFICIENCY. 24b. Were eutopsy findings evallebie prior to 24a. Wes en eutopsy performed? completion of cause of death?

Physician /Medicai Examiner

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Division of Vital Records, P.O.

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Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Physician/Medical

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			Hospitel: 1 Anpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
	Menner of Deeth 1 Deeth 2 Accident	5 Pending investigation 6 Could not be determined	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred			
	3 Suicide 4 Homicide		28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)				28f. Location (Street end Number or Rural Route Number, City or Town, Stete)			
290	Certifier (Check only one)		ysician: To the best of my kniner: On the basis of exeminand manner stated.							se(s)

within 2.

i or Attending effer death. Director: Aft

Hospital 24 hours e Funeral D

State

29b. Signature and title of certifier



29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 32 Registrer's Signeture

Registrar **DHMH 16 Rev 6/95**

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death . 1999 Month **Physician** July 27, 12:25 pm Betty Ann /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months 10 M 2X) F Days Yrs. 73 Director 579-26-8893 July 7, 1926 Wisconsin Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show Inotified at 1 X Yes 2 □ No Directo Maryland | Prince George's Greenbelt 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20770 U.S.A. 6-D Parkway Road "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: À White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked other any Injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Anna Lisa Ira Gadd 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 6-D Parkway Road, Greenbelt, Maryland John B. Farrell - Husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07/29/99 Alexandria, Virginia 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses asch 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Intarction. disease or condition resulting in death) Examiner Examiner 14y Pertension physicien and the buriei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Diubeles Box 68760. Physician/Medical Due to (or as a consequence of): Hypercholes Trolemia 080 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the s should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 2 No certificata Vital Hospital or Attanding Physician: '24 hours after death, Funeral Director: After this certificately filled in by the funerel director, g 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Jur Tarazi M.1) July 29, 1999 D48042 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Valerian Lane Rockville MD 20852 Mohammad. Surrara31 5810

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

JUL 3 0 1999

Registrar's Signature

ee 1 : 111

DHMH 16 Rev 6/95

State Registrar 32. Registracia Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Deaff **Physician** /Medical 4c. County of Deet 4a Facility Name (If not institution, give street and ou 4b. City, Town, or Location of Deeth Examiner PRINCE GEORGE'S HOSPITAL CENTER Cheverly Wunder 24 Hrs. 9. Birthplace (State or Foreign Country) Prince If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Hours Min 1□M 2√F Days Yrs Director 579-92-3150 36 March 21, 1963 Washington, D.C. Usual Residence of Deceden with the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "naturel", or Itema 23a or 28a-f show injury or other traumatic event, the Magical Examiner must be notified at 1 Yes 2 □ No Director Maryland Prince George's Capital Heights 10e. Street end Number 10g. Citizen of What Country? 1011 Frimler Court U.S.A. 14. Rece - American Indian, Funeral death 20743 11. Meditel Stelus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No 1 Never Merried 2 ™ Merried 1 ☐ Yes 2√2 No Specify: by 3 Widowed 4 Divorced Yeer or Dates: **Black** Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Environmental Services Microscopic Scientist 18. Mothar's Neme (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) Be 0 Edwena Williams Harry Jeffreys

19a. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Calvin Gray/Husband 20e. Method of Disposition 1011 Frimler Court, Capital Heights, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Washington National Cemetery 7/27/99 Suitland, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licensee CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Avenue, Suitland, MD 20746 uaThas thet ceused the deeth. Do not enter the mode of dylng, such as cerdiac or raspiretory errest a on each line. Approximete Intervel Between Onsel end Deeth **Physician** /Medical Immediete Ceusa (Finel diseese or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted evants resulting in daeth) Lasl Division of Vital Records, P.O. Box 68760 Physician/Medical consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? s been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown by 24b. Wera autopsy findings eveileble prior to complation of cause of deeth? 24e. Was an autopsy Completed page 2 2 No 1 Yes 2 No certificate Hospital or Attending Physician:
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 Funeral Director: After this certifica director. Wes case exeminer? 25. Wes case referred to medical Be 26. Plece of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 KER/Outpatlent 3□ DOA P 1 Inpatiant Dete of Injury (Month, Day Year) funeral 27. Mariner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) Plece of Injury - Al home, ferm, street, fectory, office building, atc. (Spacify) 4 Homicide pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and plece, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end manner stated. 29e. Certifier Medical

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29b. Signatural

31. Dete filed (Month, Day, Year) 1999

Dr. Meera Kanhouwa-3001 Hospital Drive, Cheverly, 32. Registrer's Signeture

30. Neme and addrass of person who completed cause of death (Item 23e) (Type, Print)

29c. License number

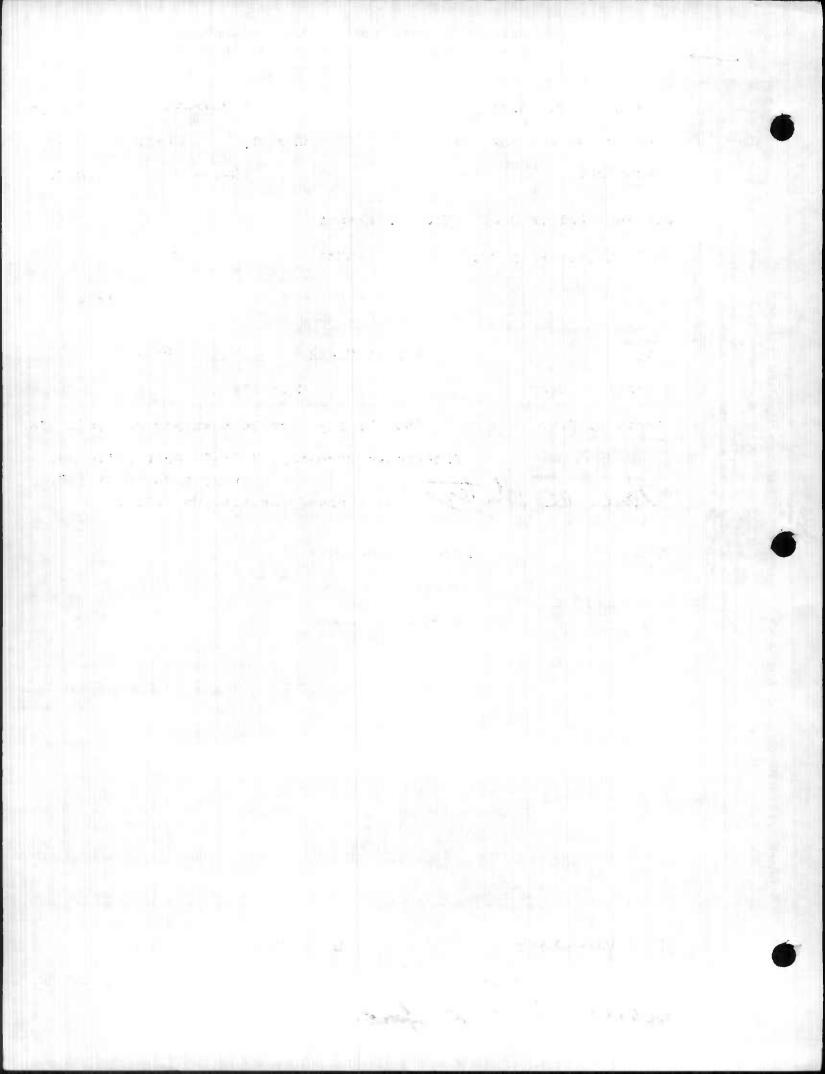
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State Registrar

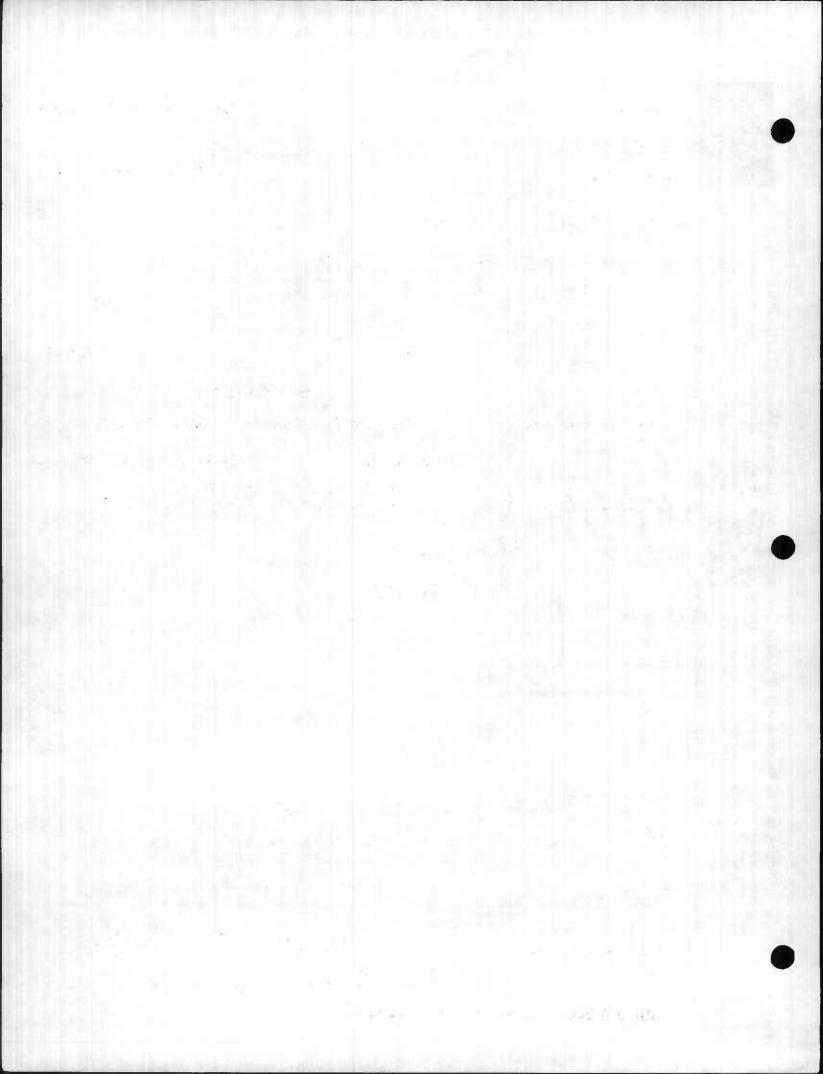
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedani's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** Gwun Elmer Gambill July 29 1999 4:00 AM /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Laurelwood Care & Rehabilitation Center Elkton Cecil 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1916 North Carolina 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 10XM 2□ F Days Hours Min. 83 **Director** 204-07-7189 Usual Rasidance of Decedani the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Machical Examiner must be movified at 1 ☐ Yas 2 No Directo Cecil Maruland North East 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda with 1 271 England Creamery Rd. 21901 USA Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. should be filled within 72 hours after and Mental Hygiene. 1 ☐ Nevar Marriad 2X Married altimore, Maryland 21215-0020 1 ☐ Yas 2 🕱 No þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry I Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Laborer Agriculture Retail 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Meiden Surnema) James Curtis Gambill Amanda Brooks and si 19a. Informant's Neme/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m Warner Gambill/Son 2010 Conowingo Rd., Rising Sun, MD 21911 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burlal 2 ☐ Cramation 3 ☐ Ramoval from State 6 4 ☐ Donation 5 ☐ Other (Specify) 7-31-99 Rising Sun, Maryland Rosebank Cemetery any Injury 21. Signature of Funeral Sarvice Licensaa 22. Nama and Addrass of Facility R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 at the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, ichard 23a. Part I Entar tha diseasa, or complications shoo, or heart failure. List only one caus Approximete Intarval Batween Onsat and Death **Physician** Immadi na Causa (Final disease or condition rasulting in death) /Medical **Examiner** a consequence of): Examiner MB attending physicien end for use as the bunal-transit certificate be executed Sequantially list conditions, if any, laeding to immadiata causa. Enter Underlying Causa (Diseasa or injury that initiated avents rasulting in daath) Lasl Dua to (or as a consequence of) P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): 98 23h. Did tobacco use contribute to the cause of death Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. the signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 Yas 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical axaminar? 26. Place of Deeth (Check only ona) Be Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 2 No 3□ DOA 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? After t Certification: 5 Panding investigation or Attending 1 Natural after death. 1 Yas 2 No 2 [] Accident 6 ☐ Could not be 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, factory, offica building, atc. (Specify) filled in by 4 C Homicide 24 hours a Hospital Medical 29a. Cartifian 1 🗹 Certifying Phyeiclen: To tha best of my knowladga, daath occurred at the time, data end plece, and due to tha causa(s) and menner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. within 2 To the 29b; Signatur 29c. Licansa number 29d. Dale signed (Month, Day, Year) 10 30. Name cause of death (Item/23a) (Type, Print MK 32. Registrar's Signatura State 3 0 1999 Registrar

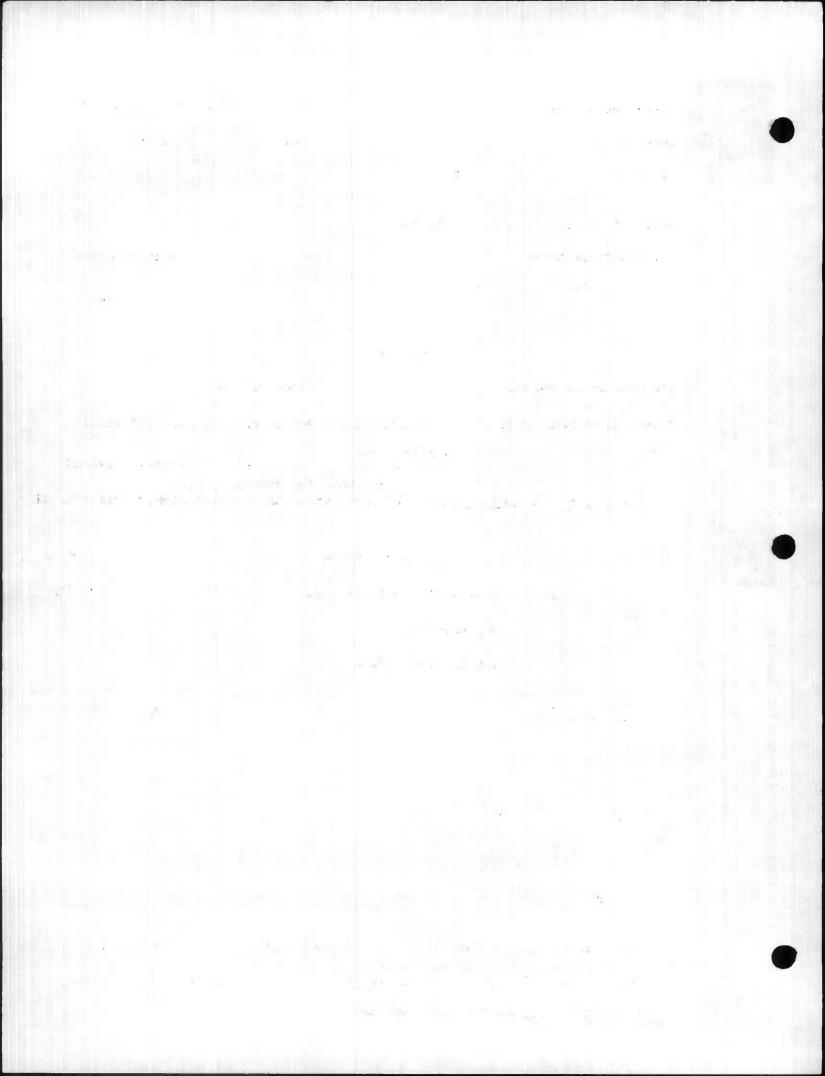


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July **Physician** 03:15 30 Jerry Leroy Helsel /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Union Hospital Elkton Cecil If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 6 Sex **Funeral** ØM 2□F Months: Days Yrs. Director 220-40-8840 56 December 20, 1942 Maryland Usual Residence of Decedent 10c. City, Town or Location 10e State 10b. County 10d, Inside City Limits the Maryla 1⊈ Yes 2 No 28a-f Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 7 fin. 21921 121 Elk Chase Drive United States Funeral "natural", or flame : 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Maritai Stelus 72 hours after 1 Never Married 2 Amarried Baltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Farmer Agriculture 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental Hy ant: if Nem 27 is marked oth lury or other traumatic event 88 Hazel M. Good Lincoln Edward Helsel 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Sharon L. Helsel/ Wife 121 Elk Chase Drive, Elkton, Maryland 21921 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, cremetory or other piece)
Gilpin Manor 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/3/99 Elkton, Maryland Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 uku 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel coed all disease or condition resulting in death) Ocalo. Examiner Due to (or es a consequence of): Examiner Due to (or as a consequence of): Aspiratel physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Box 68760. dychus ...
Due to (or es a consequence of) Physician/Medical cal PVI I P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown (R) Hew plesta should be det Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed s certificate has t director, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director. 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No 26a. Dete of injury (Month, Dey Year) funeral Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier Jui chi Hre MD 30 DU48 23 30. Neme and address of person who completed cause of death (item 23a) (Type, Print) West main st, EKton MJ HSU MD 223 JUI CHIH 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature AUG 0 3 1999

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

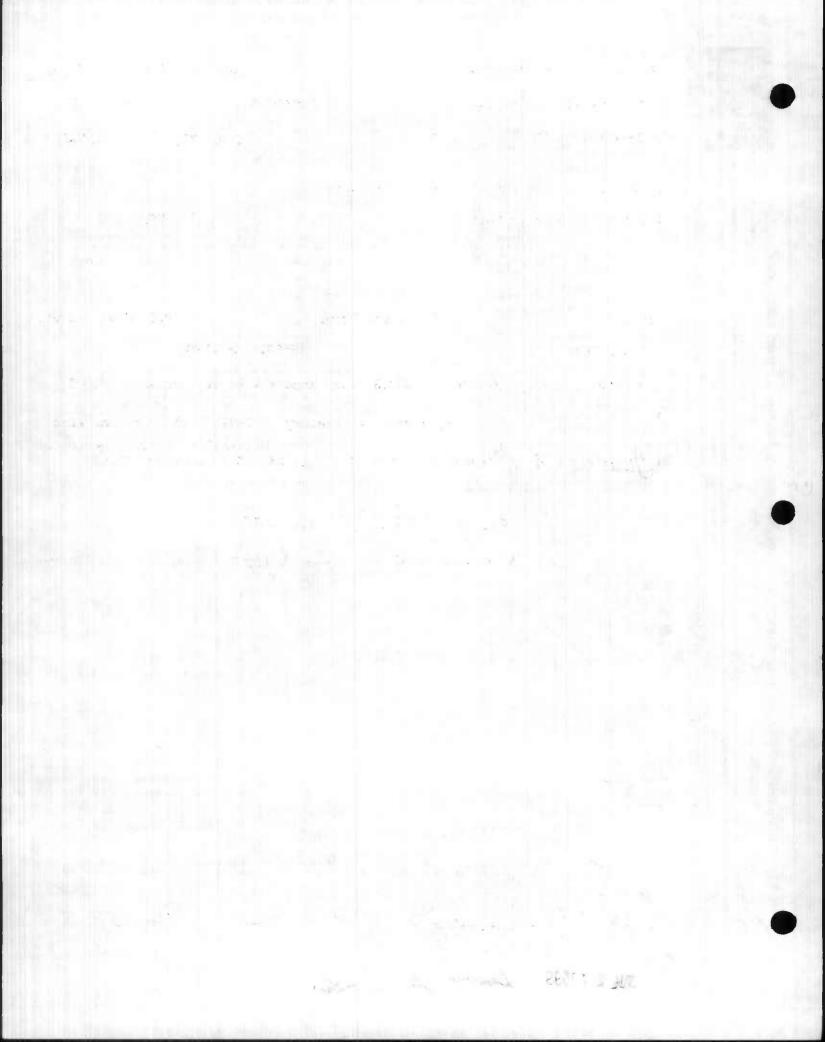
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** July 24, Thelma 9999 M. Howard 12:45 PM /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth Potomac Valley Nursing & Wellness Center Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth 382 Yrs. Months Deys Hours Min. June 25, 1917 Virginia 5. Social Security Number **Funeral** 1 M 2 F 579-09-0206 Director Usual Residence of Decedent the Maryland 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f st Director Maryland Montgomery 1 ☐ Yes 2√ No Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 9701 Falls Bridge Lane 20854 USA Funeral death items 2 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Biack, White, etc. the Medical Examiner filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married 21215-0020 ò White 1 ☐ Yes 2 No Specify: λq 3 Widowed 4 □ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Busineas/Industry (Specify only highest grade completed) other than Elementery/Secondary (0-12) College (1-4or 5+) Homemaker At Home treumatic event. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Surname, Peges 1 and 2 should be fit ment of Health and Mental Hand: If item 27 is marked oth lury or other treumatic even Be William Warren Gawen Laura Elizabeth Reamy 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Sardino/Daughter 9701 Falls Bridge Ln., Potomac, MD 20854 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1X Burlal 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 7/28/99 Cheltenham, MD 21. Signature of George P. Kalas Funeral Home, P.A. ales 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Pert Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate interval Between Onset end Death **Physician** /Medical Immediate Cause (Finai . Cardiac Arrest disease or condition resulting in death) Immediate **Examiner** Due to (or es a consequence of): Examiner Congestive Heart Failure The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last and buriel-trar Due to (or as a consequence of): physician sthe buriel Arteriosclerotic Cardiovascular Disease Box 68760. Physician/Medical Due to (or as a consequence of): Diabetes Mellitus signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed's certificate 21 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: efter deeth. Director: After this certifica Be 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours er 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D01120 July 26, 1999 30. Name and eddress of person who completed cause of death (Jam 23e) (Type, Print) Walter E. Goozh, M.D. 1299 Lamberton Dr., Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 2 6 1999 Registrar

State of Maryland / Department of Health and Mental Hygiene 🔍

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Deeth **Physician** Month Roberta Henderson :31am JUI /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince George's Doctors Hospital Lanham Under 24 Hrs. 5. Social Security Number If Under 1 Year 9. Birthplece (State or Foreign Country)
Washington, D.C. 7. Age (In vrs. lest birthdev) **Funeral** 1 □ M 2 1 ¥F Days Hours Min 71 Yrs. 578-46-1119 June 1928 Director Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ms 23a or 28a-f short man be notified a Maryland Prince George's Lanham Director 1 No Yes 2 No tha 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8200 Good Luck Rd. 20706 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bieck, White, etc. 11. Maritel Stetus 1 X Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Domestic Private 12 17. Fether's Neme (First, Middle, Last) . Pages 1 and 2 should be file ment of Health and Mental Hi lant: If Itam 27 is marked oth 18. Mother's Neme (First, Middle, Maiden Surneme) Emmitt Henderson Anna Belle Brown 19e. Informent's Neme/Reietlonship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 7709 Beechnut Rd. Capitol Heights, Md. Ernest Henderson/ Brother other 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 6 1 Burial 2 □ Cremetion 3 □ Removei from Stete Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Olivet Cemetery 7/27/99 Washington, D.C. e of Funeral Service Licenses 22 Name and Address of Fecility
Alexander S. Pope Funeral Homes 23a. Pert1. Enter the dise of a complication is thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. 20747 Approximete Intervel Between Onset end Death **Physician** Sub Arachnoid Kemantage Immediate Cause (Final disease or condition resulting in death) /Medical Examiner myocardial infaretion Physician/Medical Examiner The law requires that the deeth cartificate be axecuted the buriel-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest P.O. Box 68760, o (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? pero cymal atrial 1 No 3 Probably 4 Unknown Records, þ should be 24b. Were autopsy findings evailable prior to completion of cause of deeth? millation, Severe perphenal Completed 24e. Wes en eutopsy performed? disease Vasrulous 1 Yes 1 Yes 2 No this certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 28. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No funaral 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. injury et Work? After 5 Pending investigation 1 Naturei 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by tha 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier retifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. Medicai complately To the Within 2 29b. Signeture end fitie of cartille 29c. License number 29d. Dete signed (Month, Dey, Year) 1) 24720 7-23-99 30. Name and address of person who completed cause of death(Item 23e) (Type, Print) RAVINDER K. RUSTAGI MD
6132 Law dover Road Cheverly MD 20785 31. Dete filed (Month, Dey, Year) JUL 2 6 1999 22. Registrer's Signeture State Registrar

		Decedent's Name (First, Middle, L.)				tificate of		2. Data of De	Reg. No.	7 4.	3. Time of Death
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Exam	niner	4a Facility Nama (If not institution, gi					CHEVERI	or Location of Death Y		of Death CE GEO	RGE'S
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/land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation				100	d. Inside City Limits
e Man	ctor	Maryland Prince	George'S	S U	pper M	arlboro					XXYes 2 No
with th	Director	10e. Street and Number 16601 Village	Drive Wes	2.0		10f. Zip Code 207	72		10g. Citizen of V USA	What Countr	y?
death	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13. W			(Specify Yes or No Jerto Rican, etc.)		e - America	
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21215-0020 d within 72 hours affoliana.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		ck Driv			P.G.	Count	y Govt.
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		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [☐Removal from St	Ct Ct	emetery, crem	ition (Neme of atory or other pl		Date	20c. Location -		
Baltimo permit. Page Department of Important: If any Injury or		4 □ Donation 5 □ Other (Special Service Lice	(fy)	Res		ion Cem		7-27-99			
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m # # p	ician	Part It. Other significant conditions	contributing to deal	h but not ree	ulting in the un	derlying cause o	iven in Part I	23h Did	tohacco usa co	ntribute to 1	the cause of death?
O a the	by Physician/Me	Parti. Other argument conditions	contributing to deal		muling in the un	denying cause g	iven in Part I.		2□ No		ably 4 Unknown
aw requir	Completed b								an autopsy primed?	aval com of de	re autopsy findings llable prior to spletion of cause eath?
一 F まる	Be Co	25. Was case referred to medical					26 Place of	Death (Check only		10	Yes 2□No
D 00 0	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospitel:	atient 2	ER/Outpatient	3□ DOA O	ther:	g Home 5□ Rasi		ner (Specify)	
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Hos n 24 h Fun etaly	edicai	(Check any 4 Medical Exa	minar: On the bes	s of exeminat	ion end/or Inv	estigation, in my	opinion, deeth o	ccurred et the time,	dete end plece,	and due to t	the cause(s)
0/200) 2	29b. Signature and the of certifier				29c. Licer	nse number	10	29d. Date signe	id (Month, D	uy, Your)
(8)	/	CR) any	confidenceuse	de la constitución de la constit	220/7	D.	2069	43	1/20	188	7
0		30. Aprile and address of person with	Control of Charge	death (treff	23a) (Type, F	1/0207	tol 1	4. Che	welle	Mol	20185
S	tate	31. Date filed (Month, Day, Year)		istrar's Signal	ture &	1	-	- Crick	1	W. 40.	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death **Physician** CURLEY HARPER, JR. 07 24 99 2:05 pm /Medical 4e Fecility Neme (If not institution, give street and number) 4b, City, Town, or Location of Deeth 4c. County of Deeth Examiner Saint Joseph Hospital Towson Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral 100 M 20 F Months Devs 297-32-2343 Yrs. 61 Director Oct. 4, 1937 Ohio Usuei Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at tXXYes 2 □ No Maryland Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5315 Belleville Avenue 21207 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒No
tf Yes, Give
Yeer or Detes: 14. Rece - American Indien, Bieck, White, etc. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Stetus pemit. Pages 1 and 2 should be filed within 72 hours after 1. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or then any Injury or other traumatic event. 1 □ Never Merried 2 □ Married Specify: Black Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Animal Keeper Government 12th 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Blondine Martin Curley Harper, Sr. 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 4604 Gladys Court, Lanham, Maryland 20706 Kathryn Brooks/Daughter 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 07/30 1 KBurial 2 ☐ Cremetion 3 ☐ Removel from Stete Harmony Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Landover, Maryland J. B. JENKINS FUNERAL HOME 21. Signature of Funerel Service Licensee 7474 Landover Road, Landover, Maryland 20785 Efter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, or heart failure. List only are couse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical immediate Cause (Finet 15 months Metastatic Colon Cancer disease or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest Due to (or es e consequenca of): and Box 68760 physician Physician/Medical 8 Due to (or es e consequence of): 10 917 23b. Did tobacco usa contribute to the cause of death? Pert ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. ĝ 1 Yes 2XXNo signed by 3 Probably 4 Unknown À 2 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? **Dege 2** 1 TYes 2 K No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medicat Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 🛣 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 Sign of the 28e. Dete of tnjury (Month, Dey Year) 28c. injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: Aller 5 Pending investigation Injury 1 X Neturel 2 Accident after deat Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide hours a 24 hours Funeral 29a, Certifier 1XX Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated. Medical 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and pieca, end due to the cause(s) and menner stated. (Check only one) o the \$ 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of cartifier 29c. License number D 46118 July 27, 1999 30. Name and address of person who completed cause of death (item 23e) (Type, Print) Janet Cooper, M.D., 1447 York Road, Lutherville, Maryland JUL 2 8 1999 32. Registrer's Signeture State Registrar

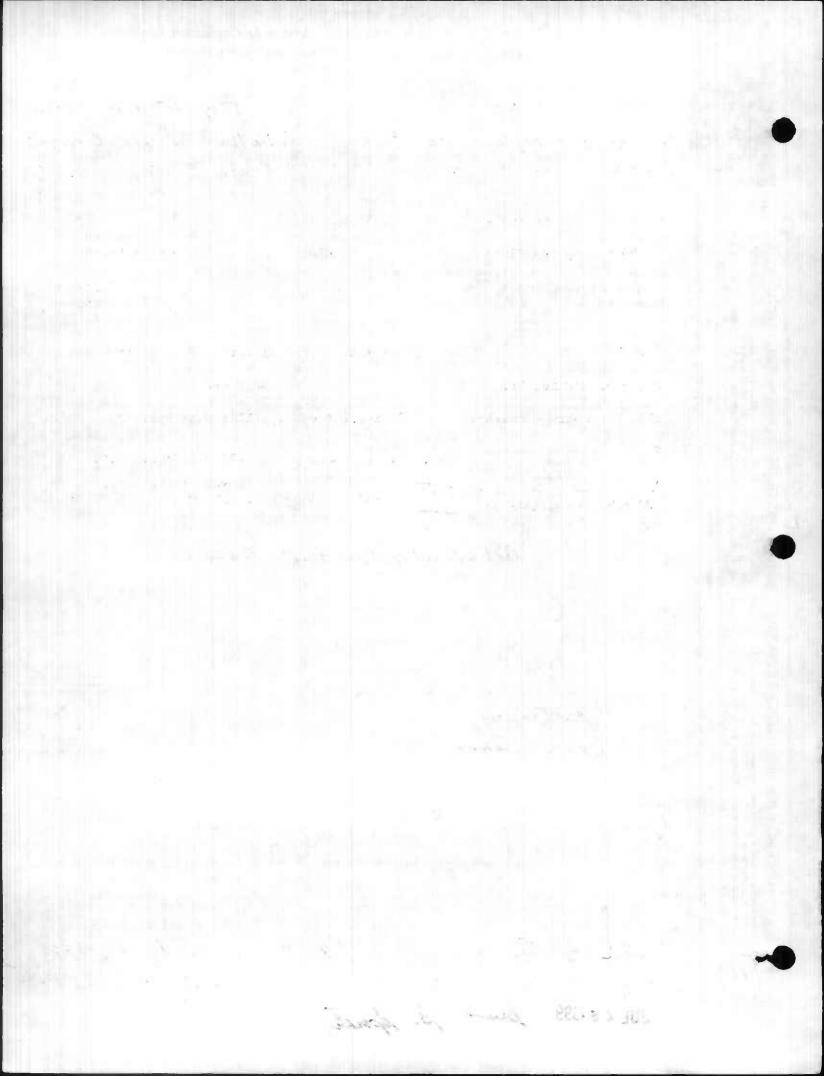


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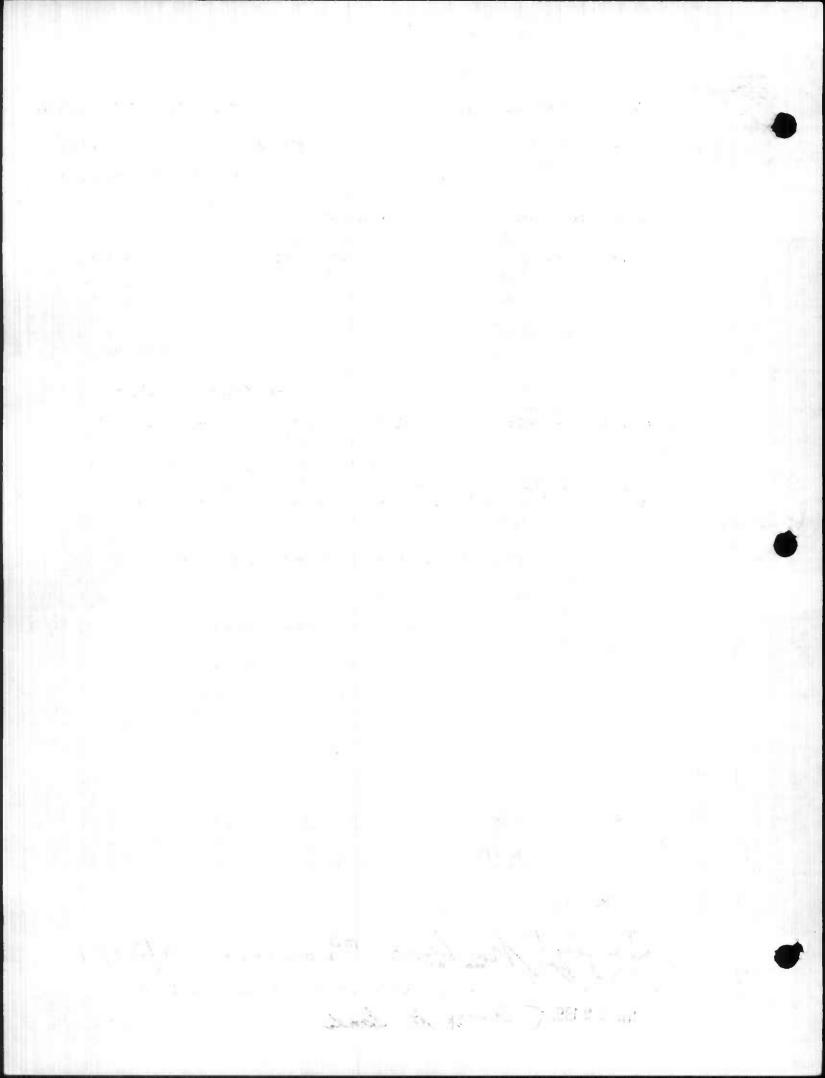
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State of Maryland / Department of Health and Mental Hygiene

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any injury or other to	21	0a. Method of Dis 1 X Burial 2 4 ☐ Donation	☐ Cremation			m Stata	cem	ce of Disponetery, crem	matory or	other pla		8/	Date / 2/99	Wash			ta
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				State of Ma	aryland	/ Depa	artment of rtificate o	f Health a of Death	and M		ene 🤵 \iint g. No.	2	5392	
			1. Decedent's Neme (First, Middle, Las)						2. Dete of Deeth)	Mark 1	3. Time of Death	
	Physici /Medi		DEWEY CLANTO	N HOLLOWAY	Y, JR.					JULY	2 ^{Dey} 1	999	6:21 PM	
	Exami		4e. Fecility Neme (If not Institution, give	street and number)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
			National Inst	itute of l	Health	l		Beth	esda		M	ontro	omery	
	Funeral		Social Security Number 6. Se	x 7.Ag	e (In yrs. las		If Under 1 Ye Months De		24 Hrs. Min.	8. Dete of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreigntry)	ign
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Maryland 21215-0020	s after or its	by Funeral	1 ☑ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 1 h If Yes, Give Yeer or Detes:			Wes Decedent of If Yes, specify C 1 ☐ Yes 2 🏋 i		, Puerto i	Rican, etc.)	Biec	k, Mile	Pean rican	
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215	Media	Completed	(Specify only highest grad Elementery/Secondery (0-12)	e completed) College (1-4or 5	4)		kind of work do DO NOT use rel			ng				
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Baltimore,	I cot H		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ F	Compared from State	20b. Plec	e of Dispo	osition (Name of matory or other)	olace)	İ	Date 2	Oc. Location -	City or To	wn, Stete	
Ë	B 新井子		4 □ Donetion 5 □ Other (Specify)		Linc	oln N	lemorial	Cem.	7	/31/99	Suitla	and,	MD	
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ш	TOESS		John !	Slewar	111		4001 Be	nning		N.E. Wa			20019	
			23a. Pert 1. Inter the disease, or composhock, r heert feilura. List only o	ications thet ceused	the deeth.	Do not ent	er the mode of	dylng, such es	cerdiec o	r respiratory arre	st,		Approximate Intervei Between	
	Physician /Medical Examiner		U	, Mul	tisy	is t	em o					1	Onset end Deeth	
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	betu d ansit	Examiner		- Mult	-161.	C	Myel	oma	-				40miTTE	5/
ć	execun and in and in items	Еха	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	211						ANT (1	6/28/90	2
8760,	certificate be executed rding physician and use as the burial-transit	dicai	thet milleted events	Bone	Due to (or es			IPAN	5 1-2	The I to	.)		9-0/11	0
9	o ph	40	resulting in death) Lest					. <		1 4	9	i		
Box	leeth certific attending p	1		Mye	10 4	A2 b	IASTI		ync	from &		<u> </u>		_
	0 9 8	sici	Pert II. Other aignificant conditions co	ntributing to death bu	it not resultir	ng in the u	nderlying ceuse	given in Pert I.		23b. Did tol	pacco usa con	tribute to	the cause of deat	h?
P.O.	T Post	Physician/M								1 □ Ye	a 2 No	3 Prof	bably 4 Unkno	WI
	8 88	by												
Records,	Ne se	Completed								24e. Wes an perform		av	era eutopsy findings alleble prior to mpletion of cause death?	3
E	는 음점	Co								1 ☐ Ye	s 2 No	10	Yes 2 No	
Vital	ysician: The is certificate director, pag	Be	25. We's cese referred to medicel examiner?	1				-7.5	of Deeth	(Check only one)			
of	Physician: this certific ral director,	2	1 165 215/40	lospitel:		VOutpetier	IL SEL DOA			me 5 ☐ Resider			v)	
Ľ.	Mer Viter	ino ino	27. Manner of Deeth 1 Netural 5 Pending	28e. Dete of Injur (Month, Da)	Year) 28	Bb. Time of Injury		njury at Vork?		28d. Describe ho	w injury occurr	ed		
Sic	Attending or death.	cat	2 Accident investigation 3 Suicide 6 Could not be	NIA				☐ Yes 2☐I		201 1 11 (0)			10	
Division	or Attending after death. Director: After in by the fune	Certification:	4 Homicide determined	28e. Plece of Inju- building, etc	iry - At home :. (Specify)	e, ferm, str	eet, fectory, offi	Ce	1	28f. Location (Str City or Town,	Stete)	er or Hura	I Houte Number,	
	Hospital 24 hours a Funeral I		29e. Certifier Certifying Phys	Italian. To the heat o	f my kanyda	dan dant		almin dess an	d alaka i				and a d	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Redical Exami	nician: To the best of ner: On the bests of end menner ste	examinetion	end/or in	vestigetion, in m	y opinion, dee	th occurre	and due to the ce ad at the time, de	te and place, a	nner as s	the cause(s)	
	To the within 2 To the comple	M	29b. Signature and title of certifier	1 /	1		29c. Lice	ense number		29	d. Dete signed	(Month,	Day, Year)	-
	- > - 0		* Lucy	Mr.	hi	211	WD		·	27	7/5	7/	99	
	(11)		30. Neme end eddress of person to co	moleted cause of de	eth (Item 2	3a) (Type	Print)	D 005	47	U 7	1/2	- 1/	11	
				HIO, M.D.			-	PIKE. F	ВЕТН	ESDA. MD	20892			
	Sta	te	31. Dete filed (Month, Day, Year)		er's Signeture		,							
	Registr	ar	JUL 2 9 1999	Dever	a ,	A.	Ann V	11						



Plea

	Please	Type or Prin	t in Bla	ck Ind	lelible lı	nk.	Assu	re Al	I Coples	Are	Legi	ble.	
		State of Ma	ryland /		rtment d			nd M		giene Reg. No	1	9 (25393
1. Decedent's Ne	eme (First, Middle, L.	ast)							2. Dete of Dee	th			3. Time of Deeth
	EDWARD	WILSON H	STLE	R					Julv	23		Yeer 999	10:30 pm
4a Facility Neme		ve street end number)	00100			4b	. City, Tow	m, or Lo	ocation of Deeth			of Death	TO: DO pill
Manor	Care -	Ruxton					Tow	son	1		Ba1	timo	re
5. Social Security	Number 6.		(In yrs. last	birthday) _ Yrs.	If Under 1 Y Months D	ear eys	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day 12/12	, Year			plece (Stete or Foreign ntry) nsylvania
Usuel Residence	1		10a Ch. T.		anti-								Ind halds Ob. I lead
PA	10b. County York		10c. City, To		rove								1 Yes 2 No
10e. Street and h	Number				10f. Zip Co	de				10g. C	itizen of	Whet Cou	ntry?
1377	Gracetor	Road				17	321			Un	ite	d St	ates
11. Maritel Stetus		12. Was Decedent E	ver in U,S.	13. W	les Decedent Yes, specify	of His	panic Orig	in? (Sp	ecify Yes or No-		14. Rac	a - Americ	can Indian,
	erried 2 X Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give Yeer or Detes:		1	Yes, specily		Specify:	Pueno	radan, etc.)		Specify	ck, White,	ite
	15. Decedent's E	ducation	WW I	Sa. Decede	ent's Usuel O	one du	lon irina most	of work	ina	16b. l	Kind of B	usiness/in	
	econdary (0-12)	College (1-4or 5		life. D	enanc	etired)	Supe			Н	osp:	ita1	
19a. Informent's Cora 20a. Method of E 1 X Buriel	Name/Reletionship D. Host1 Disposition	er/Wife	20b. Plece	1377 of Dispos	· ·	et plece	on R	oa d	ret Bel al Route Number l, Fawr Dete	G 20c. l	rove coation	State, Zij	Code)
21. Signaturd of	Funeral Service Lice	Livele	de la	22.	Neme end A	ddress	of Fecility	1					ta, PA
Immediate Ceus disease or cond	eart last re. List ont se (Finel ition	Tiplicetions that caused y one ceuse on each lin	Θ.		r the mode of					rest,			Approximete Intervel Between Onsel end Deeth
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Sequentially list if any, leeding to cause. Enter Ur Ceuse (Disease that initiated eve resulting in deet	immediate nderlying or Injury	C	Due to (or es									1	- 3
		d										- 1	
Pert II. Other sig	nificant conditions	contributing to death bu	t not resulting	g in the un	derlying caus	e give	n in Part I.		23b. Dld (obacc	0 UBO CC	ntribute t	o the causa of death?
ĺ	Renal in	usuf							10	Yes	21 No	3□ Pro	obably 4 Unknown
	CArcino	ma of	Coloi	J					24e. Wes perlo	an aut rmed?		C	fere eutopsy findings velleble prior to completion of cause i death?

Physician /Medical **Examiner** Examine

Physician

/Medical

Examiner

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mentel Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once.

Baltimore, Maryland 21215-0020

27. Menner of Deeth

1 PiNeturel

2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

(Check only one)

5 Pending Investigation

6 Could not be determined

Directo

Funeral

þ

Completed

Be

ettending physician and for use as the buriel-transit

Physician/Medical þ Completed 25. Was case referred to medical exeminer?
1 ☐ Yes 2 ☑ No Be

Certification: To

edicai

The lew requires that the death certificate be asscuted within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the e completely filled in by the funeral director, pege 2 should be detached it

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

Registrar

29b. Signeture end title of certifier

Hospitel:

28a. Date of Injury (Month, Day Year)

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end pleca, end due to the cause(s) and menner steted. 29c. License number D15871

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and menner es steted.

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Day, Year) July 26,99

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

1 Yes 2 No

28d. Describe how Injury occurred

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

LAWRENCE BOAS ND, 54 Scott ADAM Rd Cockeysville Md 21030

31. Dete filed (Month, Day, Year)

JUL 29 1999

32. Registrer's Signeture

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

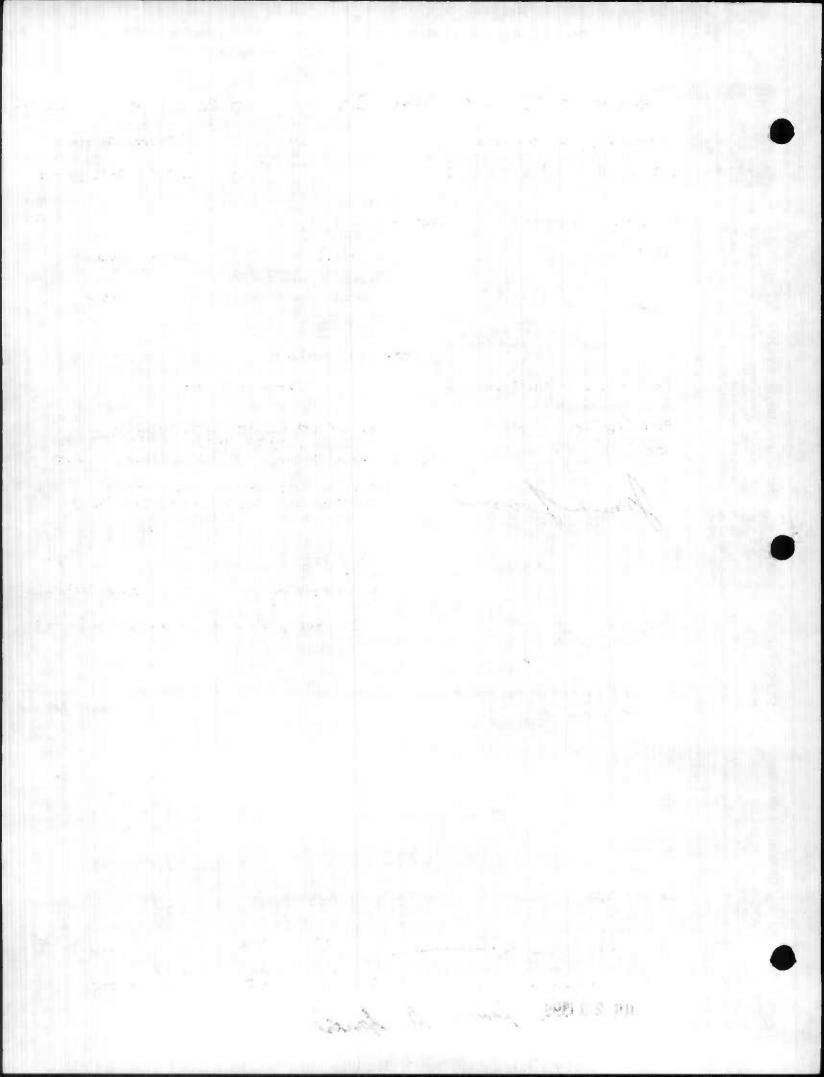
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State of Maryland / Department of Health and Mental Hygiene 🔾 🗍 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month BENITO INGALLA JR **Physician** 1540P /Medical 4s Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 6. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 228 96 3462 Yrs. 71 Director July 18, 1928 Philippines Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examines must be notified at 1 ☐ Yes 🛣 No Maryland Anne Arundel Directo Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Petes Court 21114 United States Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiena. Important: if item 27 is marked other than any injury or other trainers. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. 11. Maritei Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Never Merried 2 Married 1 ☐ Yes 2(TNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Architect/ Engineer Metro 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benito T. Ingalla, Sr. Herminia Torres 19a. fnformant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pura Ingalla Wife 1600 Petes Court Crofton Maryland 21114 20b. Place of Disposition (Name of cometery, crematory or other place) July 28, Dajeg 99 20c. Location - City or Town, State 20a. Method of Disposition 1 XX uriai 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Gardens Davidsonville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 M. Enter the disease, or emplications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, soc, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit that the daath certificata be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Physician/Medical thet initiated events resulting in death) Last USB signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown anem 15 Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peed completion of cause of death? has 1 Yes 2 Do 1 Yes 2 No Division of Vital I or Attending Physician: after death. Diractor: After this certific 25. Wes cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ ♠ b 2 ER/Outpetient 3 DOA funaral 27. Manner of Death 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital
 24 hours a
 Funerel D edical 29a. Certifier 🕊 certifying Physicfan: To the best of my knowledge, death occurred al the time, dete and place, and due to the cause(s) and manner as stated. pletaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 028998 July 24 1999 PRITAM 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) S-SAINI MD 9101 Suite 211 Lane charry Laurel

32 Registrar's Signature

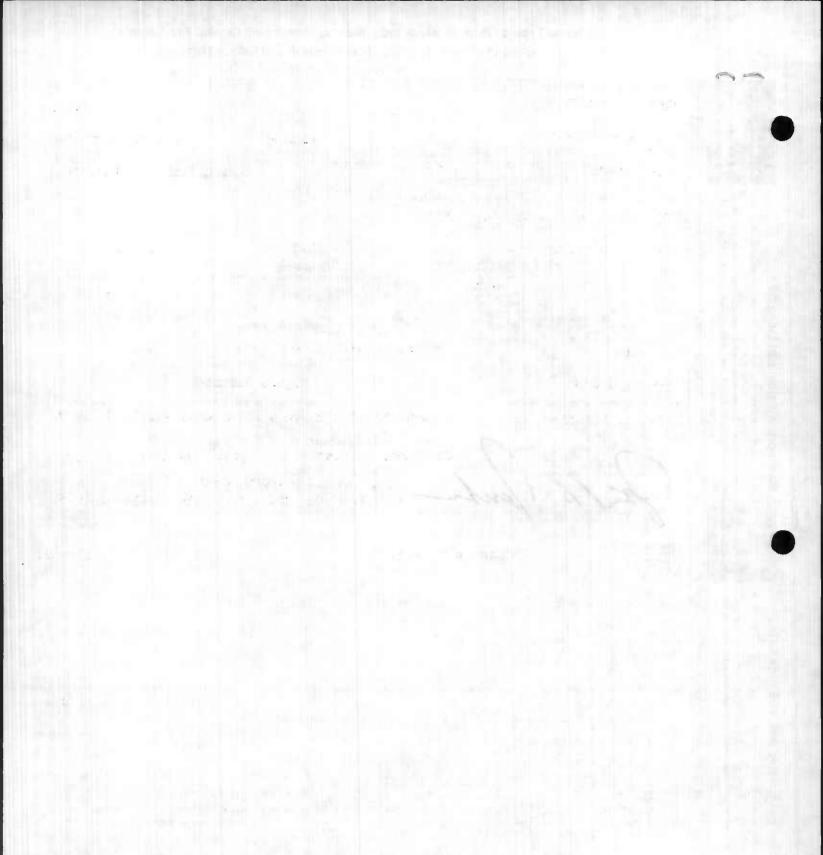
DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	DAPHNE JACK	SON	22						Month 07	2	Oay	Year 99	3:1	15pm
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Funeral Director	5. Sociel Security Number 051–66–8145	6. 9	Sex 7. /	Age (In yrs. I		Months	1 Year Days			Birth Day, Yea	ar)	9. Birthpl Coun	lece (Ste	ete or Foreig
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within To the comp	29b. Signeture and title of			000	4	290		se number		29d.	Dete signe	d (Month,	Day, Ye	er)
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State of Maryland / Department of Health and Mental Hygiene

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	Otho Thomas	Jarratt,	Jr.				July	7 23, 1	Year 999	8:43 an
	4a Facility Name (If not institu		ımber)			4b. City, Town,	or Location of De		y of Deeth	
xaminer	4014 Parkwood									
	5. Social Security Number	6. Sex	7. Age (In yrs. las	t hirthday)	If Under 1 Yes	Cottage	-			orge's
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a notifia		nce George'	S	Cottag	ge City					1110
	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?
uneral	4014 Parkwo	od Street			2072			U.S.A	7.	
miner must	11. Marital Status	12. Wes Dec	sedent Evar in U,S. orces?	13. W	Vas Decedent of Yas, apecify Cu	Hispanic Origin'i	(Specify Yes or uarto Rican, atc.)	No- 14. Ra	ce - Amari	icen Indian,
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To B	Otho Thomas	Jarratt,	Sr.			Harri	let Ann	Collins	3	
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3	Katherine M. H		Daughter		_					
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Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JEANNETTA JORDAN 10:35 PM 1999 22 JULY /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GEORGE'S 7. Age (In yrs. last birthday) If Under 1 Year Cheverly Prince Georges If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1□M 25€F Days 578-36-3556 74 Director Mar. 22, 1925 Balt. Md Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mentel Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent. Its 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Prince Georges Suitland 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2311 Brooks Drive #203 20746 U.S.A. Funeral 14. Raca - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 250 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2€ No Specify: þ 3X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 4 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clifton Brewington Bonds Etta 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Ruth King Niece 2311 Brooks Dr. #203 Suitland, Md. 20746 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lincoln Memorial Cem 7/29 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CARDIO GENIC HOURS disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner HEART FAILURE CONGESTIVE HOURS physician and the buriel-trensit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last CORONARY Physician/Medical 950 signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 DUnknown 1 Yes 2 No Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s 1 ☐ Yes 2 No 1 Yes 2X No certificate or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funerai Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Neturel 2 ☐ Accident 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Funeral C Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cartifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and menner stated.

| Medicat Examinar: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical completely (Check only one) To the within 2 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 050016 polexander MO

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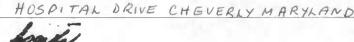
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Division of Vital Records, P.O. Box 68760

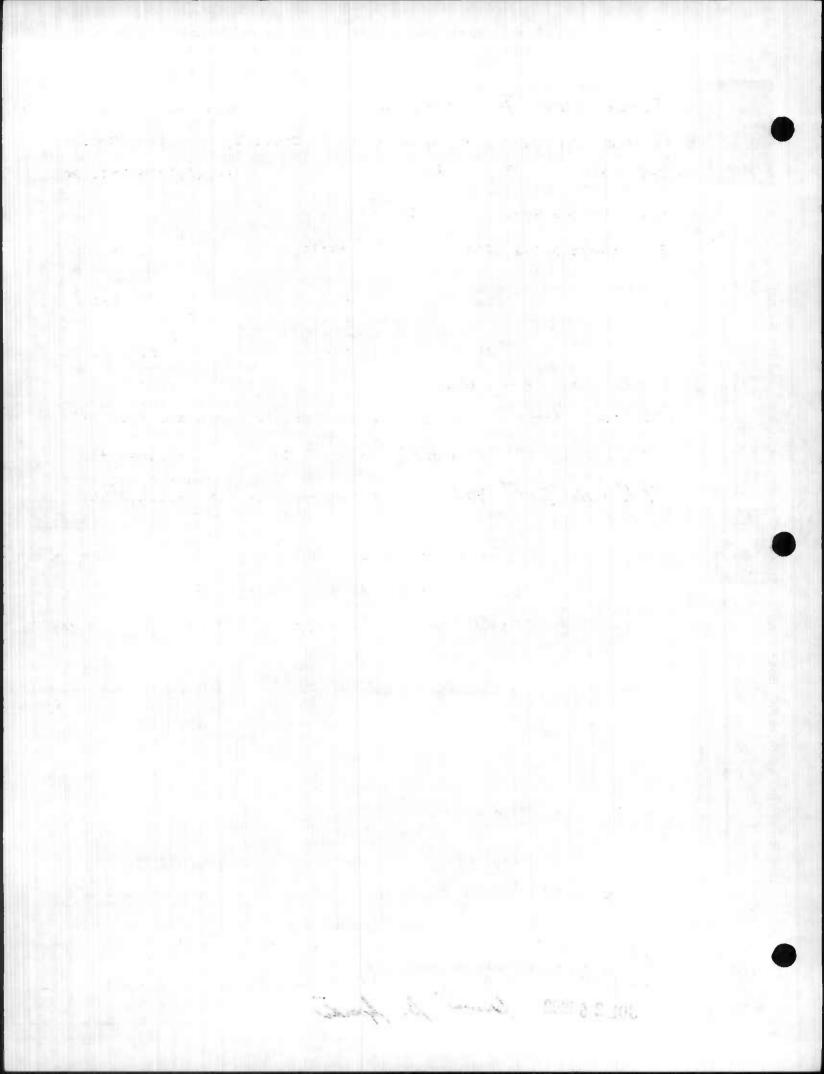
BARBARA ALEXANDER
31. Dete filed (Month, Day, Year)
32 Regil

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ER 3001
32 Registrar's Signature



State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ual Residence of Decedent a. State 10b. County 1ryland Prince 879 Long View Rd Marital Status 1 Never Married 3 Widowed 4 Divorced (Specify only highest gradementary/Secondary (0-12) 12th Father'a Name (First, Middle, Last) John A. Jamarik a. Informant's Name/Relationship (1-10) Cecil E. Jamarik Method of Disposition 18 Burial 2 Cremation 3 County 4 Donation 5 Other (Specify)	Jamarik e street and number) Cd Oaks Nursi Ex 7. Age (In y St M 2DF 9 George's 10c. 12. Was Decedent Ever in Armed Forces? 1 DYes 2 DNo If Yes, Give Year or Dates: fucation College (1-4or 5+) Type, Print) Wife Removal from State (C)	rs. last birthday) 2 Yrs. City, Town or Loc 10.S. 13. W 11 16a. Deceder (Give k 11/16.) 19b. Mailing 4879 2. Place of Disposemetery, cremedar Hill 22.	ti Under 1 Yes Months Day cation Temple 10f. Zip Code 2074 Vas Decedent of Yes, specify Cu Or Yes 2 No ent's Usual Occion of work don lachinis g Address (Street	Hills Hispanic Origin? (Street) Specify: 18. Mother's Na	8. Date of Big AMonth, Di Jan . Specify Yes or No to Rican, etc.) Trking The (First, Middle Benas Benas	7, 1999 h 4c. County Princ th Year) 1907 10g. Citizen of V U.S.A D 14. Rac Blac Specify 16b. Kind of Be Federal , Maiden Surner	year y of Death ce Georg 9. Birthplace Country) 10d. Ir 1 What Country?	ge's (State or Foreign Vania Inside City Limits Ves 2000 Von Vania						
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					24a. Was	an autopsy	24b. Were as	utopsy findings						
					perfe	ormed?	complet	e prior to tion of cause						
							of death							
					10	Yes ANO	1 🗆 Yes	2 No						
Was case referred to medical examiner?	44				ath (Check only	one)								
1 Yes 2U No		☐ ER/Outpatient	3LI DON		7									
Manner of Death		28b. Time of Injury			28d. Describe	how injury occur	red							
1 Natural 5 Pending			M 1	∐Yes 2□No										
2 ☐ Accident investigation	28e. Place of Injury - A	t home, farm, stre	et, factory, office	0	28f. Location (City or To	Street and Numb wn, State)	ber or Rural Rou	ite Number,						
2 ☐ Accident investigation	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Describe how injury occurred 28d. Describe how injury occurred													
2 Accident Investigation 3 Suicide 6 Could not be	building, efc. (Spe		occurred at the	time, date and plac	, and due to the	cause(s) and ma	anner as stated	couse(s)						
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2 Accident 3 Suicide 4 Homicide a. Certifier (Check only 2 Medical Example)	pulcian: To the best of my k	crowledge, death ination and/or invi		454										
2 Accident 3 Suicide 4 Homicide a. Certifier (Check only 2 Medical Exercise) 5 Signature and title of certifier	palcians: To the best of my k mer: On the basis of exam and manner stated.	ination and/or inve	D504	454										
2 Accident 3 Suicide 4 Homicide a. Certifier (Check only 2 Medical Exam 5. Signature and title of certifier Name and address of persop who	palcian: To the best of my kiner: On the bests of exam and manner stated.	ination and/or inve	D504	Ft. Washi		m 207//								
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ician	Decedent's Nama (F								2. Date of Month	Day		Year	3. Time of Death	
dical	HELEN		JOHNS					tb. City, Town, o	July	22		of Death	12:35F	M
niner	4a Facility Nama (If no											e Geor	rae's	
	PRINCE 5. Social Security Number	ber 6. S	OKG ES	7. Age (In yrs.	last birthday)	If Unde	r 1 Year	CHEVE		Birth 9. Birthplace (State of Country)			ian	
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ner	11. Maritai Status		12. Was Deci	edent Ever in U	l,S. 13.	Was Dece	dent of H	lispanic Origin? an, Maxicen, Pu	(Specify Yes or erto Rican, atc.)	No-		e - Americe k, White, et		
by Fu	1 Nevar Married 3 Widowed 4		1 ☐ Yes If Yes, Gir Yaar or D	2 DNo		1□ Yes		Specify:			Specify		ack	
bet		. Decedent's Ed			16a. Deced	dent's Usu	ai Occup	ation	netine	16b. Kir	nd of Bu	siness/Indu	stry	
ple	(Specify of Elementary/Seconda	only highast gra	College (1-4or 5+)	life.	DO NOT u	ise retired	during most of w	TOTATING					
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Be	17. Fathar's Nama (Firs)						lame (First, Mid		Sumem	10)		
2	Charles								ary Diggs Rural Route Number, City or Town, Stete, Zip Code)					
	19a. Informant's Name/Relationship (Type, Print) Michelle D. Maddox/Daughter 19b. Mailing Address (Street and Number or Rural Round 6817 West Forest Rd. # 1										r Town, Der	, Md.	20785	
	20a. Method of Disposit 1 A Burial 2 C 4 Donation 5 C	ramation 3		State 20b.	Place of Disponentery, cremetery, remeter, c	osition (Na matory or o COLN	me of other place.	^(ce) 7/2	7/99			City or Tow od, Md		
1916	21. Signature of Funera				22	2. Neme a	nd Addre	ss of Facility ngton &	Sons C	o. Inc	2.			
1	Xa	my.	1. 5	rate	-	4925	Burr	oughs A	ve., N.E	., Wash	2., D	.C. 2	0019	
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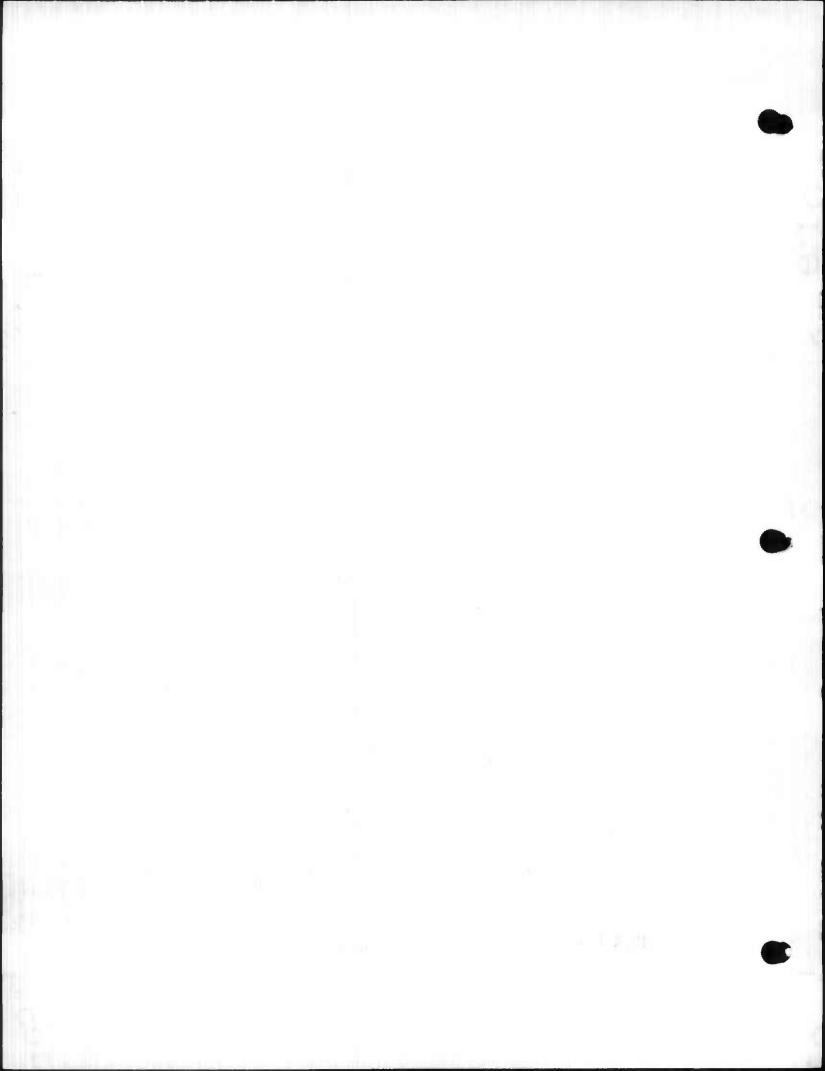
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DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

SPITAL OR INERAL DIR Ithin 72 hou NT: If Iten
IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hyplene prior to bunial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTA	L HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)	Johnson				2. DATE	OF DEATH		XEAD .	3. TIME OF DEATH 8:15 AM		
			n yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mon	OF BIRTH	'	Country	PLACE (State or Foreign		
H.	90. FACILITY NAME (# not institution, give stre Millennium Health	the Distance		96 CITY, TOWN C	OR LOCATION OF D			9c. COUNT	TY OF DE	ATH		
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY	- Transfer of		TOWN OR LOCAL				Dait	TINO			
DIR				ington						10d. INSIDE CITY LIMITS? 1 Y YES 2 NO		
IAL	10e. STREET AND NUMBER		Wasi		. ZIP CODE			10g. CITIZI	EN OF W	HAT COUNTRY?		
NEF	4601 Nannie Helen				20019			USA	1			
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ENDENT OF HISPA ecity Cuben, Mexic 2 X NO Speci	en, Puerto	N? (Specify Yes Rican, atc.)	or No-	14. RACE Black, Specify	- American Indian, White, etc. Black		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY											
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Labore				Priv	70 to				
Ø.	17. FATHER'S NAME (First, Middle, Last)		Labore	:1	18. MOTHER'S N.	AME (First,						
BE (Nathaniel Johnson,	Sr.			Ella M							
10	19a. INFORMANT'S NAME (Type/Print)	0			nd Number or Rural			n, Stete, Zip C	Code)			
	Nathaniel Johnson,	205	PLACE AND DATE OF		treet C	amder		08103 CATION — CI		on Charles		
	1 [XBurist 2 Cremation 3 Ramov 4 Donation 5 Other (Specify)	al from State came	orest Hi]	Is Ceme	tery	1						
- 6	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MAD CITAT T. 1. C. TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYDD AT TYPYYD T											
	Limberly Chriscoe 16mic 4308 Suitland Road Suitland, MD 20746											
CERTIFICATION	23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, abock, or heart fellura. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury											
	resulting in death) LAST											
MEDICAL	PART II. Other algnificant conditiona	contributing to deeth bu	it not reaulting in	the underlying	ceuse given in	Part I.	24s. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES		UNCERTAI	NΠ		(1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH	(Check only one)								
IXSI		I inpetient 2 ER/Outpe	tient 3 🗆 DOA /	1	5 - Residence	6 🗆 Othe	er (Specify)					
	Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	RY WO	RK?	28d. DE:	SCRIBE HOW IP	NJURY OCCU	RED			
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28s. PLACE OF INJURY building, atc. (Specific	At home, ferm, str	M 1 YES 2 NO At home, farm, street, factory, offics 28f. LOCATION (Street), for fown, Sta					pet and Number or Rural Route Number, are)			
COMPLETED	29e. CERTIFIER (Check only one) 29e. CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29e. CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
TO BE C	20% BORNATIRE AND TITLE OF CERTIFIER	7.			D2		0			Month, Day, Year)		
-	30. NAME AND ADDRESS OF PERIODS WHO WHO A DURA L.	RABH	AKAT	rine) ZM'O	2115	OL	000	EMS	CUA	0 KALTIMU		
	JUL 2 7 1999	32 REGISTRAR'S SIGNA	B.	outs!								



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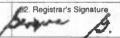
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Discrete to a	1. Decedent's Neme (First, Middla, La		1 1			2. Date of Dea Month	th Day	Veer	e of Death		
Physician /Medical	Lorene	J	ohnsto	n		July	24	1999 4	:45 PM		
Examiner	4a Facility Name (If not institution, given Laurel Re		ospital		Lai	ure/		ce Geo			
Funeral Director	578-28-0380	DM ONE	rs. last birthday) 38 Yrs.	If Under 1 Year Months Days	if Undar 24 H Hours Mi		, Year)	9. Birthplace (Sta Country) North Car			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show raumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Usual Residence of Decedent 10a. Stata 10b. County Maryland Prince 10e. Street end Number	George's	City, Town or Lo	Laure1			10g. Citizen of V	1 🕅	e City Limits Yes 2 No		
h with	14200 Laurel F	ark Drive		2	0707		Unite	ed States	3		
alf, or Nems 234 Engriner must by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Evar fn Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🎇 No	dispanic Origin? an, Mexican, Put Specify:	(Specify Yes or No- arto Rican, etc.)	14. Race Blac Specify	- American Indian k, White, etc. : Black	1,		
72 ho	15. Decedant's E (Specify only highast gro		16a. Deced	dent's Usual Occup kind of work dona DO NOT usa retire	ation during most of w	vorking	16b. Kind of Bu	siness/Industry			
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6	30. Name and address of person who	completed cause of death (II	tem 23a) (Type,	Print) Duse 1	20 #9	220 L	aurel	1008	20707		

State Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Data of Death 3. Tima of Death **Physician** WILLIAM HENRY JONES, JR. JULY 23, 1999 1:30AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Nursg. Examiner 2015 EAST WEST HIGHWAY/Fox Chase Rehab. Ctr. SILVER SPRING MONTGOMERY COUNTY If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) If Undar 1 Year 5. Sociai Security Number Birthpiace (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days 50 Yrs. Director 578-66-0544 April 19, 1949 Washington, D.C. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington, D.C. 15 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2411 Minnesota Ave. S.E. 20020 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ №6/30/70 If Yes, Give Year or Datas: 3/30/75 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black g 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) William Henry Jones, Sr. Eleanora Hager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Depertment of Health and Important: If Item 27 ie n any Injury or other traun pncs. Cynthia Beckwith/Sister 2411 Minnesota Ave. S.E. Washington, D.C. 20b. Place of Disposition (Neme of cematery, crametory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify) 7/29/99 Laurel, Md. Maryland National Cem. 22. Nama and Addrass of Facility
Alexander S. Pope Funeral Homes 21. Signatura of Funeral Sarvice Licensee Ci. M1085 5538 Marlboro Pike/Forestville, Md. 20747 P r11. Inter the disease or comprise ions that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Intervai Between Onset and Death METASTATIC BLADDER CANCER **Physician** MONTHS /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical that initiated events resulting in deeth) Last Due to (or as a consequence of). 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To 1 Yas 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7/23/99 D42403 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REET #218, WASHINGTON PC 20010 RAJ MATHUR 106 IRVING STREET #218, WASHINGTON PC 20010

Registrar

31. Date filed (Month, Dey, Year, JUL 2 7 1999 32 Registrar's Signature

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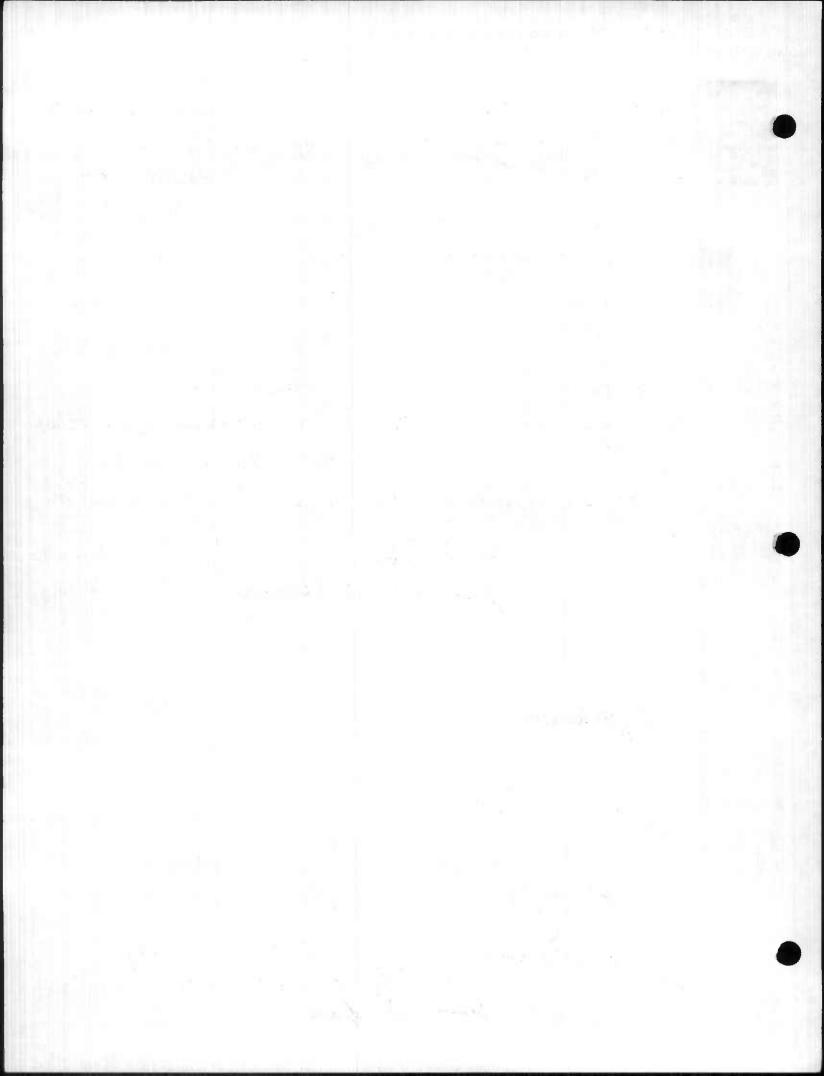
Baltimore, Maryland 21215-0020

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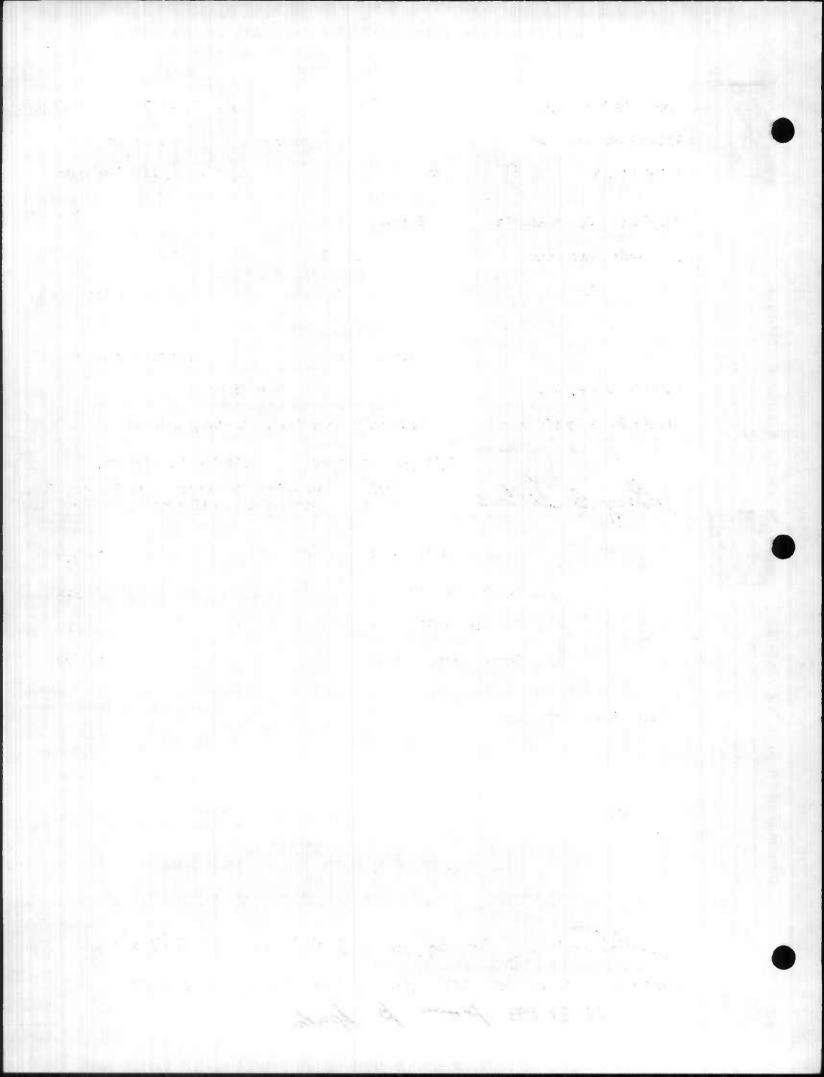
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 27, Genevie Kathleen Knight 1999 8:30 p.m. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** 1104 Goldsboro Road Barclay Queen Annes If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days Months 1□M **XX**F Yrs September 11, 60 1938 New Jersey Director 141-30-9814 Usual Residence of Decedant the Marylend 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 7 is merked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at 1 Yas 2 No Directo Maryland Queen Anne's Barclay 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mentel hygiene. Important: If Itam 27 Is marked other than "natural", or Itams 23a or 2 1104 Goldsboro Road 21607 USA Funeral 12. Was Decadant Ever in U,S. Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Rece - American Indien, 11. Marital Stetus Black, White, atc. 1 Naver Married 2XXMarried 1 ☐ Yas 2 ☒ No If Yas, Giva altimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Wicker Furniture 18. Mothar's Nama (First, Middla, Melden Surnama) 17. Fether's Name (First, Middle, Last) Be Phillip Moore, Jr. June Simmons 20 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Jimmie P. Knight/Husband 1104 Goldsboro Road, Barclay, MD 21607 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 5 7/29/99 Clarksboro, NJ Eglington Cemetery 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee. Fellows, Helfenbein & Newnam Funeral Home, P.A. 21a Part Error of disease, or complications that coused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, Approximate Intarval Between Onset and Deeth **Physician** /Medical tmmediete Causa (Finai Rheumatoid Arthritis disease or condition resulting in death) 20 yrs Examiner Dua to (or as a consequence of): Examiner Morbid Obesity 20 yrs law requires that the death certificate be executed physician and the buriel-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Diabetes Mellitus 10 Yrs Physician/Medicai Dua to (or es a consequance of): USB as ettending Chronic Lung Disease 10 yrs Por Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown Sleep Apnea Syndrome þ 24b. Wara autopsy findings evailable prior to completion of ceuse of death? 24e. Was en eutopsy Completed peen page 2 1 ☐ Yas 2 ☐No 1 TYes 2 No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was cese referred to medical axaminar? 26. Piace of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2XXNo 10 funeral 27. Mannar of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 X Vetural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Sulcida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 4 I Homicida 24 hours 29e. Cartifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the tima, deta and place, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, deta end place, and due to the cause(s) and manner stated. edical To the Hosp within 24 hou To the Funer completely fil 29c. Licansa number 29d. Data signed (Month, Dey, Year) 29b. Signeture end title of commit 8 , MD 30. Name and accrass of person who completed causa of death (Itam 23a) (Type, Print) Elizabeth P. Sipala, CRNP, 2217 Millington Road, Millington, MD 21651 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State JUL 28 1999

Registrar



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Me	29b. Signatura and titla of certifiar			29c. Licans	sa number		29d. Data signa	d (Month,	Day, Year)
)	1000 m	M.D.		D51006			July 24th, 1999		
	30. Name and address of person who co	empleted cause of daath (Item 300) 1+05p. Ta	23e) (Type, Print)	Che	verly	MD	2078	35	
State legistrar	31. Data filad (Month, Day Year) JUL 2 8 1999	32. Ragistrar's Signati	ura .	-					

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Fu	ixaminer ineral rector	6. Social Security Number	reet Sex 7. Aga (In y)	rs. last birthda 52 Yrs.	Į.	If Under 24 Hrs Hours Min	T Height	th Year)	e 6e	e (State or Foreign		
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h the	reci porti	10e. Street and Number	ocorge 5	Latino	10f. Zip Code			10g. Citizen of Wi	hat Country	?		
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21215-0020 d within 72 hours after death with the Manyland giene.	To marked other than "naturel, or frems 25s or 25s-f enow treumstic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11, Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar In Armed Forces? 1 ঐYes 2 □ No If Yes, Give Year or Dates:	U,S. 13	B. Was Dacedent of H If Yas, specify Cub 1 ☐ Yes 2 No	fispanic Origin? (S an, Mexicen, Puer Specify:	Specify Yes or No to Rican, atc.)	14. Race Black Specify:	- American , Whita, etc			
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yland 21215- ould be filed within 72 Mental Hygiene.	t, its Medical	Elementery/Secondery (0-12)	College (1-4or 5+)	1	. <i>DO NOT</i> use retire Postal Car			Cove	ernmeı	nt		
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00, e executed	physician and the burial-transit the burial-transit clical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury C.										
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Divisi		3 Suicide 6 Could not to determined		home, farm, s	street, factory, office			Street and Numbe wn, State)	r or Rural R	loufa Number,		
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To the	2	29b. Signature and title of certifier	2		29c. Licens	se number		29d. Date signed	(Month, Da	y, Year)		
1	2)	Sal Syl	STW , DO		1	11504		July 2	27/	999		
12	0/	30. Name and address of person who completed cause of deeth (item 23a) (Type, Print)										
(, ,	_	31. Date filed (Month, Dey, Year)	32 Registrar's Sig	It os	pital s	mivy (reve	ry, 19.	ary/c	ind		
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State of Maryland / Department of Health and Mental Hygiene 25507 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** JOSEPH E. LINDSAY JULY 26,1999 10:30pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 14216 N. GATE DRIVE SILVER SPRING MONTGOMERY If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Hours Days Months 1 XM 2 ☐ F Yrs. 578-38-6272 73 9 - 3 - 25WASHINGTON DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yas 2 No Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14216 N. GATE DR. 20906 UNITED STATES Funeral 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🗓 Married 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE MARKETING CONSULTANT 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 OSCAR LINDSAY MARTHA HILL 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSLYN B. LINDSAY / WIFE 14276 N. GATE DR. SILVER SPRING, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burlal 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 17-31-99 SILVER SPRING, MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOME pre 11315 LOCKWOOD DRIVE, SILVER SPRING,MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel PANCREATIC CANCER 8 MONTHS disease or condition resulting in death) Due to (or as e consequence of): Examiner Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in daath) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examinar: 1 ☑ Yas 2 ☐ No Hospital: Other: 4☐ Nursing Home 5 \$\text{N}\$ Residence 6 ☐ Other (Specity) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending 1 TYas 2 No investigation 2 Accident 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

| Medical Examinar: On the basis of examination and/or nvastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) igetion, in my opinion, death occurred at the time, date and place, and dua to the causa(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifie

The law requires that the death certificate be execu Records. Division of Vital or Attending Physician: Hospital

Box 68760.

P.O.



Funeral

Director

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Physician /Medical

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After

24 hours after death.

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Baltimore, Maryland 21215-0020

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State

30. Nama and address of person who completed cause of death (Item 23a) (Type

D07390 rint)

JULY 30,1999

ALLEN M. MONDZAC M.D. 2141 K ST. VN.W. WASHINGTON DC 20037

31. Data filed (Month, Day, Year) JUL 3 0 1999

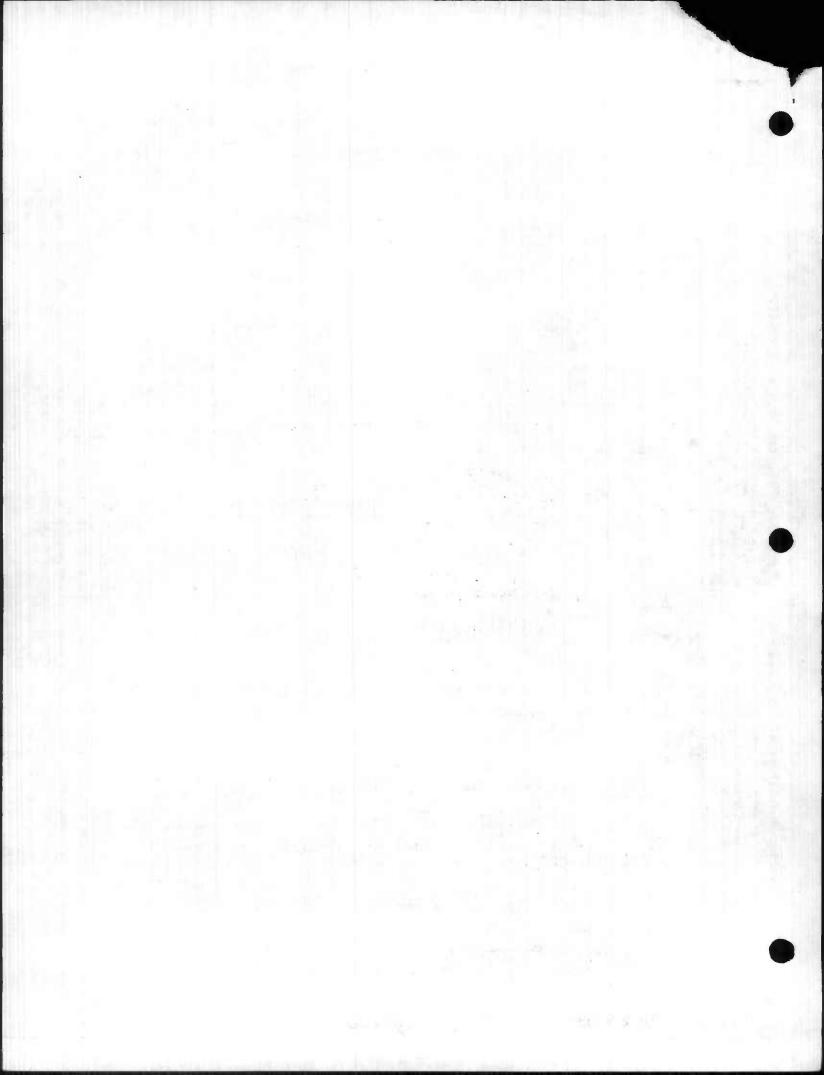
32/Registrar's Signature

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Registrar

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aminer	4a Facility Name If not institution,	give street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
	Good Samaritan H	ospital			Balt	imore			
eral		Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthplace (S Country)	tate or Foreign
ctor	220-22-4119 Usual Residence of Decedent		97 Yrs.			September		Mary	land
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led for	Maryland		D = 1 +	d				12	Yes 2□No
Director	Maryland 10e. Street and Number		Balt	imore			10g. Citizen of V	Vhat Country?	
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Exactor must be notified at by Funeral Director	11. Marital Status	12. Was Decedent E	ver in U,S. 13.	Was Decedent of H	lispanic Origin? (Sr	pecify Yes or No-	14. Race	e - American Indi	9 ก,
Fur Fur	1 Never Married 2 Married				an, Mexican, Puerto	Rican, etc.)		k, White, etc.	
by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Detes:		1 ☐ Yes 2 ☑ No	Specify:		Specify	White	
Completed	15. Decedent's (Specify only highest of		16a. Dece	dent's Usual Occup	nation	cina	16b. Kind of Bu	siness/Industry	
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Co		2		Homemaker				n Home	
Be	17. Father's Name (First, Middle, La	st)			16. Mother's Nem	e (First, Middle,	Maiden Surnam	10)	
7	Benjamin Marple				Annie T				
	19e. Informant's Name/Relationship	(Type, Print)			and Number or Ru				
Je.	Margaret Kees /] 20a. Method of Disposition	Daughter	4008 20b. Place of Dispo	Glenmore	Avenue,	Baltimon Date	ce, MD	21206	100
or other treumatic event, the M To Be Comp	1 ☑ Burial 2 ☐ Cremation 3	□Removel from Stete	cemetery, cres	natory or other place	ce) I.	July 23	20c, Location -	City or Town, St	Na.
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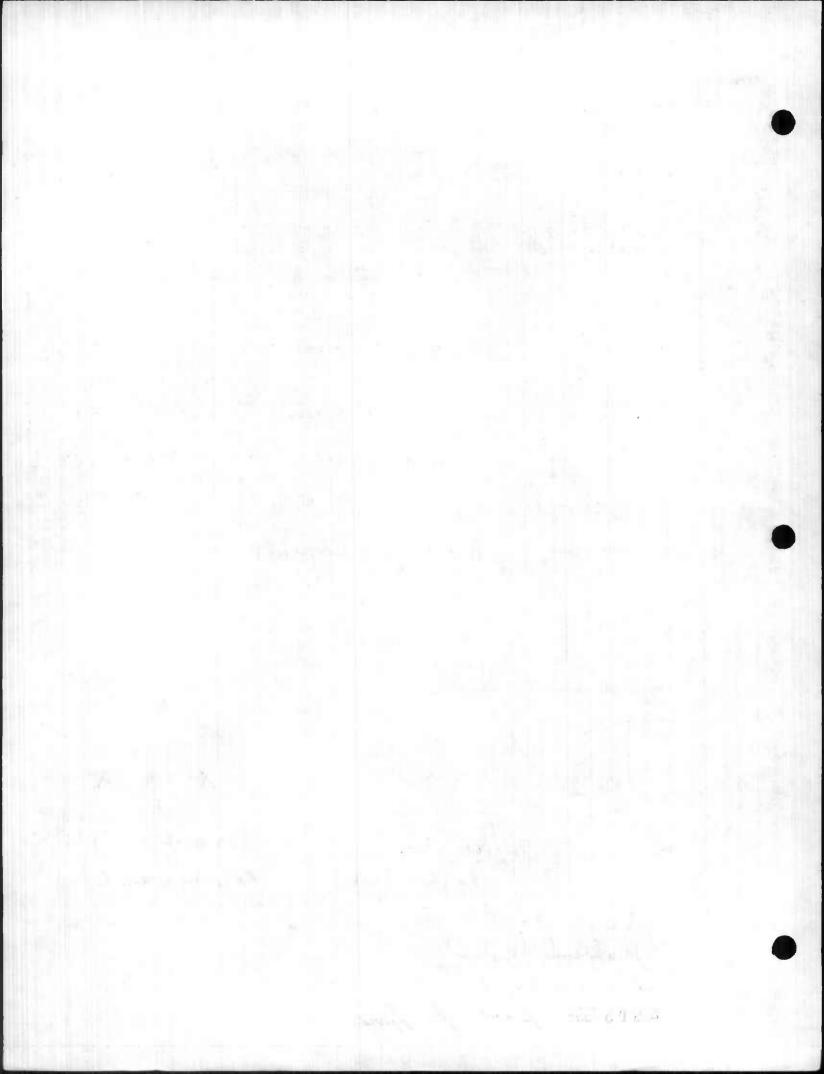


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State of Maryland / Department of Health

and	Mental Hygiene	99	2540	19
7	Rea No.			

						Ce	rtificate of	f Death	7		Reg. No.		
		1. Decedent's Neme (First, Mi	ddle, Last)							2. Dete of Dec		Mari	3. Tima of Death
Phys	ician dical	Edwin Harv	ev Le	edom	1					Month JULY	30. 19	Year	2350 PM
100	niner	4e Facility Neme (If not institu	tion, give stre	et end nu	m <i>ber)</i>					cation of Death	4c. County	of Deeth	
		BIG ELK CREEK	BRIDO	GE-EL	K MILL	S ROAD		ELK	TON		CEC	CIL	
Funer	al	5. Social Security Number	6. Sex	_		rs. last birthday)	If Under 1 Year Months Dey		24 Hrs.	8. Dete of Birth	h Ward a o	9. Birth	place (State or Foreign ntry)
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P.		Usual Residence of Decedent			140	O							
anyla ahov	-	10e. Stete 10b. Cour				City, Town or Lo	ocation						10d. Inside City Limits
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18 y 2	Dire	10e. Street end Number	0				10f. Zip Code		921		10g. Citizen of \U.S.		ntry?
ath v	Funeral Director	45 Willow											
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5-0020 72 hours after death with the Manyland natural, or Norm 23e or 28e-f show deal Examine Instit to notified at	by F	Never Merried 2 N 3 Widowed 4 Divorce		1 Yes, Gir	ZE No		1□ Yes 👷 N	o Specify	:		Specify	wh	ite
15-002 n 72 hours natural',	D D			Yeer or D	etes:	16a Dana	dantia Haval Occ	unation			10h Kind of D	unine and fin	-duate.
15	Completed	(Specify only hig		ompleted)		(Give	dent's Usuel Occi kind of work don DO NOT use retir	e during mo:	st of workin	ng	16b. Kind of Bi	usiness/in	oustry
2121 d within piene. r than r	mc.	Elementery/Secondery (0-12 1 2	2)	College (1	1-4or 5+)				Con	tracti	ing se	lf e	mployed
nd 212 e filed withi al Hygiene. other than		17. Father's Neme (First, Midd	le, Last)			police		_			Meiden Sumen		
ylan ould be Mental arked o	To Be	Donald E	. Lee	dom				Eve	lyn	Seagra	aves L	eedo	m
# SPEE	F	19a. Informant's Neme/Reletic	onship (Type,	Print)		19b. Meili	ng Address (Stree	et end Numb	er or Rurai	l Route Numbe	er, City or Town.	State, Zia	o Code)
and 2: saith ar 27 is er trau		Donald Leedo			er	399	ng Address <i>(Stree</i> Deaver	Rd.,	Elkt	on, Ma	arylan	d 21	921
re, N is 1 and of Health itam 27 l		20a. Method of Disposition			20b	. Plece of Dispo	osition (Neme of		1	Dete	20c. Location -	City or To	own, State
00-		Buriel 2 Cremetic		ovel from			Comotor		8	15/00	Fikto	n. N	Maryland
In the state of th		24 Cleanburg of Funcial Control Control Control											aryrana
B S S S		80111	J. D						Ge		eral H		(arv1and
m		23a. Pert1. Enter the disease,	1105		anned the de							11, 14	faryland
		shock, or heart feilure, L	ist only one	ceuse on e	ech line.	etti. Donot en	ter the mode of d	ying, such as	s cardiac of	i tespiratory er	1051,		Approximata Intervel Between Onset end Deeth
Physicia /Medica	_	Immediata Causa (Finei											
Examine		disease or condition resulting in death)	a		1100	CLCD	le 11	74	res				
	6				Due to	(or es a conte	quence of):					1	
betr	edical Examiner		b		0		- 0						
), exect n and al-tra	Exa	Sequentially list conditions, if any, leading to immediate cause Finer Underlying											
x 68760, ertificate be executed ling physician and e as the bunal-transit	ca	cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequenca of):											
68 ficat gphy	Pa	resulting in death) Last	1		Due to	(or es a consec	(uenca or):						
X Cer Cer	2		d									-	
Geeth death e atter	Ca	Pert II. Other significant cond	Itlane contrib	uting to de	eath but not o	esulting in the u	nderhina cause c	iven in Pert	1	23h Didt	obacco use co	atribute t	to the cause of death?
O # # #	Physician	Total other algument cond	tions continu	oung to de	sain but not n	aaditiii g iii tiia o	indenying cause (jivon ar r an	1.	101	M	3 □ Pro	
S, P	by P										72.10	00.10	Jacoby 4 Grandwin
ords requires een sign hould be	8									24e. Wes	en sutopsy		ere autopsy findings
() _ 00	e e									репо	rmed?	CC	vallable prior to ompletion of cause i death?
I Rec The law ate has t page 2 s	Completed									M	(aa		
= F # a		25. Was case referred to medi	ral .							1 PC		1	Yes 2 No
f Vital Ry ysician: The I is certificate hi director, page	o Be	examiner?	Hos	pitel:			-55-0-10	Whor		(Check only o			COENE
of Vita Physician: r this certific aral director,	-	Yes 2 No 27. Manner of Death	1	28a. Date	of Injury	☐ ER/Outpaties 28b. Time o	N 3LI DOA	4U N			ence 6 KUROth		SCENE .
Division or Attending after death. Director: After d in by the fune	Certification:	1 Naturel 5 Pan		7 Moni	th, Pay Year)	2725	W	ork? □ Yes 2	. 1	In her of	velilo	sta	ex by Train
Vision Attending r death. ector: After by the fune	fica	3 Suicide 6 □ Cou	id not be	28e. Placa	of injury - At	home, farm, st	reet, factory, office	,		81. Location (S	Street and Numb	per or Rur	rel Route Number,
DIV after Direction	T	4 Homicide	mined	buildi	ng, et (Spe	gily) A	Do. to		R	City or Ton		Mil	0 1
DIVISION O To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	2	29e, Certifier 1 ☐ Certif	vina Physick	an: To the	best of my ki	nowledge deet	n occurred at the	time, date a	nd plece. a	and due to the	ceuse(s) and m	anner as	s resort
Hoa 24 h	edical			On the be			vastigation, in my						
To the within To the	ž	29b. Signature and title of certi	fier /				29c. Lice	nse number			29d. Dete signe	d (Month,	Dey, Year)
FSFO		11/11/15	10	0-	dr.		C	.C.M.	E.		JULY	31,	1999
/		30. Name and address of person	NO MEDICAL	leted com	a ol door ("	om 22a\ /T	Deint\						
6		CT (AL	(> C	- CAUS	^	em 23a) (Туре, 11 Penn	Street,	Balt	imore	, Marvl	and 212	201	
	tate	31. Date filed (Month, Day, Yel	31)	32. A	egistrer's Sig					1-			
Regis		AUG 0 3 199		Gene	-		bouls						



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200	State of Maryland / Department of Health an Certificate of Death	Reg. No. 99 254 10							
hysician /Medical	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Sully 25 1999 8 5								
Examiner uneral rector	Livingston Health Care Center Ft. Wa 5. Social Security Number 051-09-5362 6. Sex 99 Yrs. Ft. Wa Ft. Wa 99 Yrs. Ft. Wa 99	shington Prince Georges Hrs. B. Date of Birth Vin. Nov. 25, 1899 Ac. County of Death Prince Georges 9. Birthpleca (State or Foreign Country) Finland							
or items 23s or 28s-f show miner must be notified at 7 Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Temple Hills	10d. fnside City Limits 1 ☐ Yes 2 ☑ No							
il Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country? USA							
by Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes or Dates: 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	? (Specify Yes or No- uerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White							
Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 4th 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Carpenter	working 16b. Kind of Business/Industry Construction							
To Be C	17. Father's Name (First, Middle, Last)	Name (First, Middle, Meiden Surname)							
	19a. Informant's Name/Relationship (Type, Print) William M. Lenck/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	emple Hills, MD 20748 Date 20c. Location - City or Town, State 7/29/1999 Brentwood, MD							
poce	21. Sgnature of Funeral Service Licensee 22. Name and Address of Eacility George 1. Kalas	Funeral Home, P.A. d., Oxon Hill, MD 20745							
d be detached for use as the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Pulmurary Dixon							
Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?							
Completed by F		24e. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?							
	OF 145 4 44 # 4	1 Yes 2 No 1 Yes 2 No							
Medical Certification: To Be	examiner? 1 Yes 2 No	Deeth (Check only one) ng Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Aca, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)							
Medical Certification: 1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R.A. McConna	7-26.99 ughy, M.D.							
State	1/4/8 Civins Im Rend Fg. Wash 31. Date filed (Month, Dey, Year) 32. Registrar's Signature	ring for MD 20744							
Registrar	JUL 2 6 1999 Separa B. Angel								

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State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death		Reg. No.	31 6	0411			
Di visi	1. Decedent's Neme (First, Middle, La		2. Date of Dea Month	ath Day	Year	3. Time of Death						
Physician /Medical	Betty Lit	tle				July		999	4:02PM			
Examiner	4a Facility Neme (If not institution, giv				4b. City, Town, or	Location of Death						
\$4	12102 Hickory Dr				Ft. Wash				orge's			
Funeral Director	092-34-2574	To Age (In yrs.		Months Deys	If Under 24 Hrs Hours Min							
D *-	Usuat Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits											
with the Maryline or 28a-f sho be notified at Director	N 1 1 D 1 0 1 1 7 T 1 1 1											
23a or 2 ant be m	10e. Street and Number 12102 Hickory Dr	744		10g. Citizen of W Unite	that Countried Sta							
72 bours shar death with the Maryla natural; or harns 23a or 21a-f sho sical Examiner, must be notified at sted by Funeral Director	11. Marital Statua 1 □ Never Merried 2 ☒ Married 3 □ Widowed 4 □ Divorced	1 Never Merried 2 Married 1 Process 1 Process 1 Process 2 No. 1 Process 2 No. 1 Process 2 No. 2			Hispanic Origin? (5 ban, Mexican, Puel Specify:	Specify Yas or No- no Rican, etc.)	r No-) 14. Rece - American Indian, Black, White, etc. Specify: Black					
d within 72 hours at piens. Than "natural", or then "natural", or the Medical Exam.	15. Decedent's Ed	Jucation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Bu	stry				
ad within 72 ho tygiens. we than "naturn it, the Medical. Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retin	during most of world)	orking	king					
The state of the s	Elementary/Secondary (0-12)	5+ Nurse					Private					
S SETTE	17. Father's Nama (First, Middle, Last)			110	18. Mother's Na	ma (First, Middle,	Maiden Sumame	e)				
Mental Mental Mental To B	John Tobi	.as			Ge	raldine	Gilliard	i				
and 2 aho saith and 3 n 27 is ma er trauma	19a. Informant's Neme/Relationship (ing Address (Stree 2 Hickory									
Tan Tan Office	20a. Method of Disposition	20b.	Place of Disp	osition (Nama of metory or other ple		Dete	20c. Location -	City or Tow	n, Stata			
. Pages 1 a Iment of Hea lant: If Nem dury or other	1 Donation 5 Other (Specify	F	t. Lin	coln Ceme	etery	7/26/99	Brenty	wood,	MD			
Departiment of the parties of the pa	21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019											
	23a. Pert / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Deeth Immediate Cause (Finet disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
lew requires that the death certificate be executed les been signed by the estending physician and a 2 should be deteched for use as the buriel-transit npleted by Physician/Medical Examiner												
of the death certain the bath of the estendir leteched for use Physician/A	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to t											
ss that the death cer igned by the ettendir be deteched for use by PhysicianA	Varia. Galar agrinoan contantoris o	out of the control of						1 Yea 2 No 3 Probably 4 Unknow				
The lew requires trate has been signe, page 2 should be Completed by						24a. Was perfo	an eutopsy rmed?	com	e autopsy findings lable prior to pletion of cause eath?			
2 20 0						101	res 2 No	10	Yes 2□ No			
Physicien: The law this certificate has the ral director, page 2 s TO Be Comple:	25. Wes case referred to medical				26. Place of De	eth (Check only o	ne)					
hysicianis cerul direc	axaminer? 1 ☐ Yes 2 X No	Hospitat: 1 Inpatient 2	ER/Outpatie	nt 3 DOA O	hor	g Homa 5 Rasidence 6 Other (Specify)						
tal or Attending Physicien: ns effected: After this certification is Director: After this certification: To Be (Certification: To Be	27. Magner of Death 1 Neturel 5 Pending invastigation	28a. Date of Injury (Month, Day Year)	28b. Time o	W		-	cribe how injury occurred					
bal or Attending P in effer deeth. In Director: After it and in by the funera Certification:	3 Suicide 6 Could not be detarmined	28t. Location (Street and Number or Rural Route Number, City or Town, Steta)										
To the Hospital or a within 24 hours after to the Funeral Direction of	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exert	ysician: To the bast of my kno ilner: On the basis of examine	owledge, deal ation and/or in	th occurred at the to exestigation, in my	ima, data and plac opinion, death occ	e, and due to the curred et tha tima,	cause(s) and mai data end plece, a	nnar as sta and dua to t	led. ha cause(s)			
Me Me								d. Data signed (Month, Day, Year)				
100		010	•				7 - 22 - 99					
(10)	30. Name and address of person who	clowy M	m 23a) (Type	, Print)	6102							
(19	ADRIENNE J. 31. Date filed (Month, Day, Year)	CCPMP M	D	5100 AL	UH WA	4 Sui	TLAND	MD	20746			
State Registrar	JUL 2 7 1999	Some	A	Spark	,							

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State of Maryland / Department of Health and Mental Hygiene

ysician					Cert	ificate	of Death		Reg. No.	fis (1 60	
VSIRIAI	1. Decedent's	Neme (First, Middle	a, Last)					2. Date of De Month	eeth Day	Year	3. Tima of Death	
Medical	Alonza	Alonza Berkeley Motley						July		999	2:40 am	
aminer	4a Facility Nar	ne (If not institution	, give street and nu	mber)			4b. City, Town, o	r Location of Deet	th 4c. Count	y of Deeth		
	Lorier	Nursing	& Rehabi	litatio	n Cente	r	Columbi	a Howard				
ral or	5. Social Secur 212-18		6. Sex 1 ፟፟ M 2 ☐ F	7. Age (In yrs. 85		If Under 1 Months C	Year If Under 24 Hr Deys Hours Mir	n. (Month, De	rth ey, Year) 27, 1913	9. Birthplac Country	e (State or Foreign	
	Usual Residence							вере.	27, 1713	VILBII	114	
To Be Completed by Funeral Director	10a. Stete	10b. County		10c. C	ty, Town or Loca	ation				10d	Inside City Limits	
To.	Maryland Howard Columbia									1 ☐ Yes 2 No		
Director	10e. Street and					10f. Zip Co	ode		10g. Citizen of	What Country	?	
	622/ 0	edar Lan	•				21044		U.S.A.			
era	11. Maritel Stat			edent Ever in U	J.S. 13. W		it of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No		ce - American	Indien,	
by Funeral	1 Naver !	Merried 2 Marri	Armed Fo led 1 ☐ Yes If Yes, Gi Year or D	2 No			Cuban, Mexican, Pue	nto Rican, etc.)		ck, White, etc by: Whit		
ted	,	15. Decedent			16e. Decede	nt's Usuel C	Occupation	- 4-1	16b. Kind of B	itry		
Completed		Specify only highes Secondary (0-12)	collega (1-40r 5+)	lifa. DC	O NOT use	done' during most of w retired)	orking				
E		12			Restau	rante	ur		Owner			
BeC	17. Father's Ne	me (First, Middle, I	Last)				18. Mother's N	eme (First, Middle	, Maiden Sumer	me)		
ToB	Alonza	Berkele	y Motley				Mary Fr	ances Al	len			
-	-	's Neme/Relations!			19b. Mailing	Address (S	Streat and Number or I	Rural Route Numb	ber, City or Town	, Stete, Zip Co	ode)	
			Daughter				f Lane, El					
	20e. Melhod of		Daughter	20b.	Pleca of Disposi	tion (Neme	of	Dete	20c. Location		, Stete	
	1 X Buriel	2 Cremation	3 Removal from	State	cemetery, creme	story or othe	er pieca)	07/06/00				
		ion 5 Other (Sp		Fo				07/26/99		ood, Ma	ryland	
- Carron	21. Signeture of Funeral Service Licensee Claudette d. Dasch Service Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20										20781	
	23a, Part 1. En	ter the disease, or	complications that	aused tha dee			of dying, such es cardi			A	pproximete itervel Between	
ın	Silver and an artist and artist artist and artist and artist artist and artist artist and artist artist artist and artist artin artist artist artist artist artist artist artist artist artist										nset and Death	
al er	Immediata Causa (Final disease or condition rasulting In daeth) e. A final fi										ap	
	rasulting in dae	eth)	B. 14	Dua to (as a conseque	enca of):					0	
Je l			mue	nº 10/4	1 De	man to	-			11	ns	
Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying									10,00		
EX									190	0		
S.												
edicai Examin	resulting in death) Lest Due to (or as a consequence of):											
3			d									
<u>a</u>							1	23h Did tahacca use contribute to the cause of doubt				
Physician/Medical	Part II. Other significant conditions contributing to death but no				sulting in the und	ertying ceu	se given in Part I.		23b. Did tobacco use contributa to the cause of death			
								1 🗆	Yes 2 No	bly 40 Unknow		
d by								040 1410	e an autanni	24h Warn	autopsy findings	
4									s an autopsy formad?	aveile	able prior to	
d)										of de	ath?	
npiet								1 🗆	Yes 2 No	101	res 2□ No	
Complet							26. Placa of D	eeth (Check only	ona)			
Be Completed		referred to medical			ER/Outpetient	3□ DOA	Other: 4 Nursing	Home 5 □ Res	ridence 6 🗆 Ot	her (Specify)		
o Be	exeminer?	referred to medical	Hospitel:	Inpatient 2		Too.	A		how injury occu			
To Be	exeminer? 1 Yes 27. Menger of 0	20 No Deeth	28e. Dete		28b. Time of	280	Work?					
To Be	exeminer?	No Deeth 5 ☐ Panding	28e. Dete (Mon	Inpatient 2 Confinence of Injury th, Day Year)	28b. Time of Injury	M 280	. Injury et Work? 1 ☐ Yes 2 ☐ No					
To Be	exeminer? 1 Yes 27. Menuer of C 1 Vivieturel 2 Accide 3 Suicide	No Deeth 5 Panding investig 6 Could n	28e. Dete (Mon	of Injury th, Day Year)	Injury	М	1 Yes 2 No	28f. Location	(Street and Num	ber or Rural F	Route Number,	
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To Be	exeminer? 1 Yes 27. Menger of [1\times Accide 3 Suicide 4 Homic 29a. Cartifier (Check only	Deeth 5 Panding int Investig 6 Could in datermi	g physician: To the Examiner: On the band man	of Injury th, Day Year) of Injury - At h ng, etc. (Speci	Injury nome, ferm, streefy)	M pat, fectory, conceived et stigation, in 29c. L	1 Yes 2 No Iffica the time, date and plessmy opinion, deeth occurrence.	28f. Location City or To	own, Stete)	nannar as stat , and dua to th	ed. na cause(s)	
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Certification: To Be	exeminer? 27. Menger of I 1\(^2\) Neturel 2 \(^2\) Accide 3 \(^3\) Sulcide 4 \(^1\) Homic 29a. Cartifier (Check only one) 29b. Signeture	No Deeth 5 Pandin, Int Investig 6 Could in datermi Certifying 2 Medical E and title-of cartifier	28e. Dete (Mon not be ned 28e. Plecs build g Physician: To the and man	of Injury th, Day Year) of Injury - At h ng, etc. (Speci best of my kn asis of examina ner steted.	Injury nome, ferm, stree fy) owledge, death contion end/or inve	M et, fectory, concurred et estigation, in	1 Yes 2 No Iffica the time, date and plessmy opinion, deeth occurrence.	28f. Location City or To	e ceuse(s) and m data and place.	nannar as stat , and dua to the	ed. na cause(s)	

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State of Maryland / Department of Health and Mental Hygiene

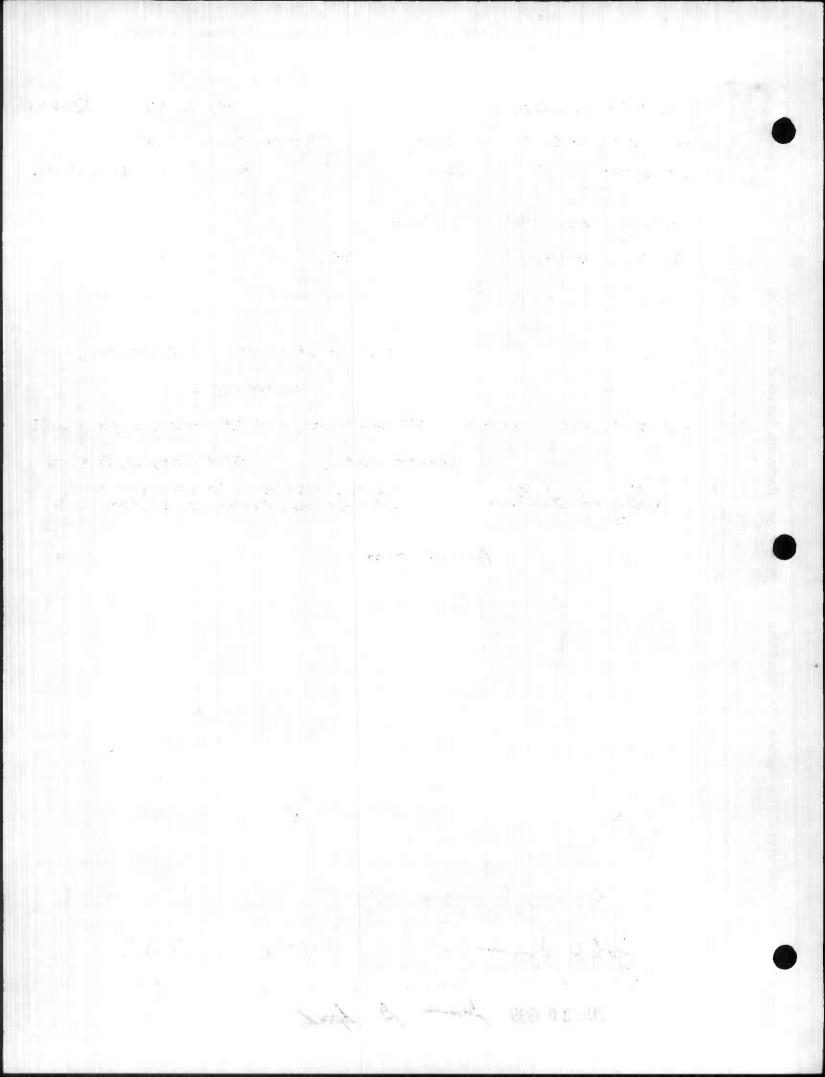
Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Deeth Day **Physician** Miller 7-1 7-99 4:15pm Ada Lowery /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Medical Center Cheverly Prince Georges 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2XX Yrs. 577-92-6993 Director Wadesboro NC 2 - 28 - 13Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f shot trsumstic event, the Medical Examiner must be notified at 1 Yes 2 No Md Prince George Landover Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3424 Dodge Park Rd T3 20785 USA death Funerai 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiena.
snt: if item 27 is marked other than "natural", or item ury or other traumatic event, the Medical Examination. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0020 1 Yes 2 No Specify: Black p 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 11 Housewife 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Charlie Lowery Della White 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) M Miller(Daughter) 1838 M St NE #3 Washington DC 20002 Eva altimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date XIXBurial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: if any Injury or once. Forest Hills Cemetery 7-24-99 Clinton Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Sterling Funeral Service 21. Signeture of Funeral Servica License Lasen 1601 Kenilworth Ave NE Wash DC v 20019 23a. Pert1. Enter the disease, or some lications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or es a consequence of): . Examiner eumo ne tran Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Lest pue Due to (or as a consequence of): Box 68760 physician 20 Physician/Medical 94 Due to (or as e consequence of): 8 980 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 200 No B 3 Probably 4 Unknown 1 Yee Division of Vital Records. þ 8 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No To Inpatient 2 ER/Outpatient 3 DOA ä 28a Date of Injury (Month, Dey Year) funeral 28c. Injury et Work? 27. Mapner of Death 28d. Describe how Injury occurred 28b. Time of Certification: Attending Natural 5 Pending I or Attendin after death. Director: Att 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 24 hours a edical 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) end manner stated. Within 2 å 29d. Date sigged (Month, Dify, Year) 29c. License number 29b. Signeture end title of certifier m 7,0 30. Name and address of person who completed cause of deeth (Jern 23e) (Type, Print) P.G. Medical Center Cheverly, Md 20785 Catevenis, M.D. James 31. Date filed (Month, Dey, Year)
JUL 2 6 1999 32 Registrer's Signature State Registrar

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 25414

			Certificate of Death Reg. No.										
98370783	4	1. Decedent's Neme (First, Middle, Last)						2. Date of Deeth Month , Dey Y			3. Time of Death		
Physic		Douglas Calvin Miller, S							1999	Yeer	10:05 P.M.		
/Med Exam		4e Fecility Neme (If not institution, give street end n				4b. City, Town,	or Location of D	eath	4c. County	of Deeth			
\$10 Hall Marks		Chestertown Nursing & Re	er			Chester	ctown		Kent				
Funera Directo		5. Social Security Number 6. Sex 1 M 2 □ F	7. Age (in yrs. les 74	t birthday) Yrs.	If Under 1 Months I	Year Deys		Hrs. 8. Dete of (Month, Novemb	Birth Dey Ye	1924	Coun	elece (Stete or Foreign itry) Maryland	
show	7	Usual Residence of Decedent 10a. Stete 10b. County			own or Location						10d. inski		
he M	Director	Maryland Queen Anne's Millington 109. Street and Number 109. Citizen of What								Mhat Caus			
23a or 3	ral Dir	213 Lime Landing Road			21	651			U	ISA			
Nore, Maryland Z1Z15-UUZU ges 1 and 2 should be filed within 72 hours after deeth with the Meryland nt of Health and Mental Hygiena. If them 27 is marked other than "natural", or items 23s or 28s-4 show or other traumatic event, the Medical Express must be nothered.	by Funeral	1 Never Married 2 Married 1 Yes, 0	Armed Forces? 1 ☐ Yes 2 ②No If Yes 6 ive			Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) □ Yes 2 No Specify:					r No- 14. Rece - American India Black, White, etc. Specify: White		
Maryland 21215-UU20 nd 2 should be filed within 72 hours af th and Mental Hygiena. 77 is marked other than "natural", or r traumatic event, the Medical Exern	Completed	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						. Kind of B	usiness/Inc	dustry	
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E H	BeC	17. Fether's Name (First, Middle, Last)						Name (First, Mid	ldle, Mai	den Sumen	10)		
id be ked	ToB	Louis Miller				Emma 1	Lee Joyn	er					
Shou M M	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (S	Street		r Rural Route Nu		ity or Town,	State, Zip	Code)	
Ma 2 mith a 27 is r tra		Jeanette Wallace Miller/	Wife	213 I	lime L	and	ing Roa	ad. Mill	ingt	on. M	arvl:	and 21651	
othe othe		20a. Method of Disposition	20b. Plac	a of Dispo	sition (Neme	of		Dete		. Location -			
E G E E		1 Buriel 2 □ Cremation 3 □ Removal from 4 □ Donetion 5 □ Other (Specify)	n State	pton	Cemet	ery		7/28/9	9 Cr	rumpto	n, Ma	aryland	
Demit. Department importu		21. Signeture: Funeral Service Licensee 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral 130 Speer Road, Chestertown, Maryla 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.									ral I	Home, P.A.	
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that the d	y Phy								1 Yes 2 No 3 Probably 4 Unkno				
INVISION OF VITAL RECORDS, P.O. BC for Attending Physicien: The law requires that the deeth after deeth. Director: After this certificate has been signed by the atter in by the funeral director, page 2 should be detached for the control of the c	Completed b								Vas an e erforme		8V	ere autopsy findings allable prior to impletion of ceuse deeth?	
The The Pege	On							1	☐ Yes	2 No	1[☐ Yes 2☐ No	
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ION OF nding Phys th. :: After this e funeral di	ation:	27. Manner of Death 1 P Naturel 5 Pending (Mc) 2 Accident investigation	e of Injury onth, Dey Year)	8b. Time of Injury	f 280	c. Inju Wo				Injury occur			
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omp	Me	29b. Signature and title of certifier			29c. License number					29d. Date signed (Month, Dey, Year)			
->-0		1 Auc An - 17-1382						f	7-28 55				
		30. Name end address of person who completed cause of death (Item 23a) (Type, Print)											
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	ata	7	Registrar's Signetur	e				wii, Mary	Land	_2162	U		
Regis	tate trar	JUL 3 0 1999	Serve	/	9. d	ba	de						

Registrar



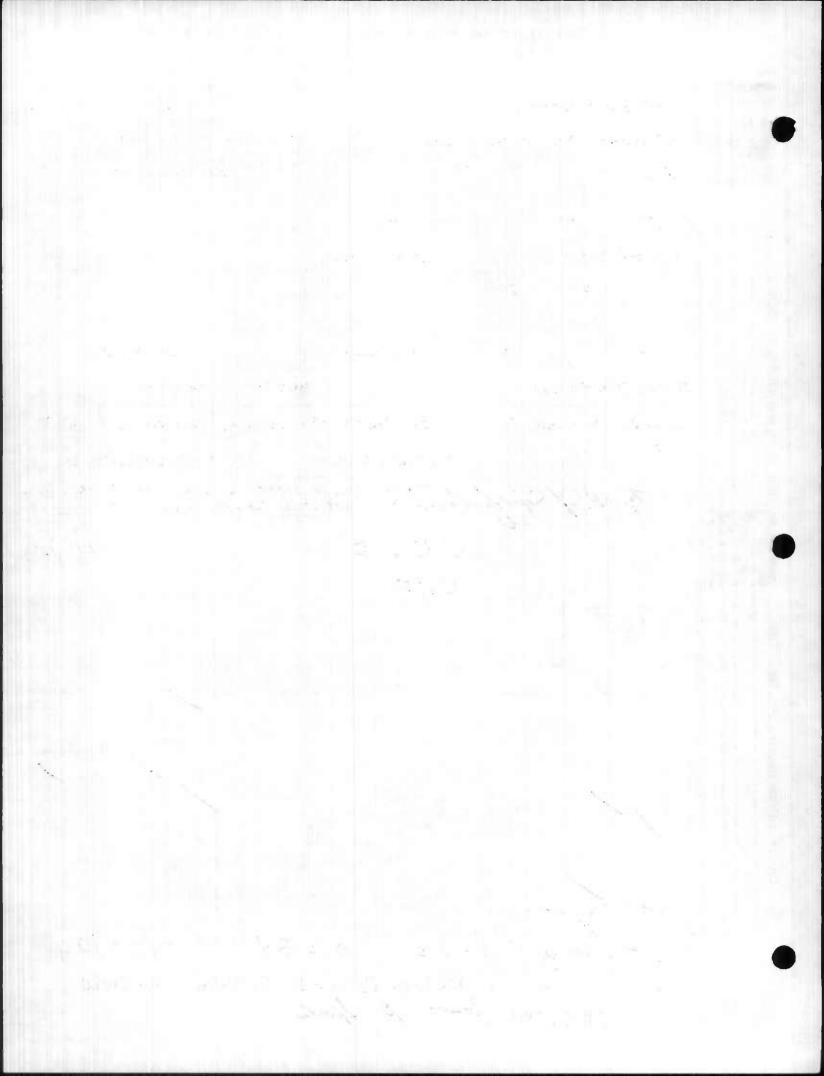
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** July 23, Robert Edward Moorman 1999 1:00 p.m. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7828 Country Club Estates (Residence) Chestertown Kent If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
December 13, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months 10XM 20 F Deys 70 Director 406-28-7900 Kentucky Usual Residence of Decedent the Meryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits worle 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at Yes 2 No Directo Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7828 Country Club Estates 21620 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 □(Yes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origh? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes No Specify: White Specify: permit. Peges 1 and 2 should be filed within 72 hours a Department of Heelth and Mental Hygiene. Important: If item 27 ie marked other than "naturef", o þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Credit Union 12 Management 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Walter John Moorman Mary Bernadette Newman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Jean Moorman/Wife 7828 Country Club Estates, Chestertown, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State injury or 4 □ Donation 5 □ Other (Specify) 5/26/99 Stevensville, MD St. Pauls Cemetery 22. Name end Address of Fecility 21. Signeture of Funerel Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. 23e. Part 1. Enter the disease or complications in caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician and the burial-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be execu Box 68760. Physician/Medical Due to (or as e consequence of): 80 950 signed by the e 23b. Did tobaceo use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peed page 2 1 ☐ Yes 2 ☐ No 1 TYes 2 0 No certificate Division of Vital or Attending Physician: 25. Was case referred to medical director, 86 26. Place of Death (Check only no) exeminer' Other: 4 Nursing Home 5 Residence 6 Other (Specify) O_L 1 Yes/ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manper of Death Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation 1 Naturel Injury after death. Director: Af 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide n 24 hou. Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated. may basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of 29c. License number O. Neme and address of person eted cause of deeth (Item 23e) (Type, Print) 120 Speer RD Suite II Chestertown MD 21620 ShanaHAN, MD PATRICK 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95**

State



State of Maryland / Department of Health and Mental Hygiene

		•	(Certificate of	Death		Reg. No.	3 6	2416
Physicia		D. Moody				July	27, Dey 199	9 Year	3. Tims of Death 9:30P.M.
/Medica Examine	4a Casiliba Mama III and Ingeliado	n, give street and number) alth of Sout!	hern 1	Maryland	4b. City, Town, o	r Location of Deat		of Death	
Funeral Director	5. Sociel Security Number 578-78-8487	6. Sex 1 M 2 DF 7. Age (In	yrs. last birthe	Months Dave	If Under 24 Hr Hours Min	n. (Month, Di	th ly, Year) 9,1955	9. Birthpl Count Wasi	lace (Stete or Foreign fry) 1., D.C.
Maryland H ahow	Usual Residence of Decedent 10a, Stete D • C • 10b. County		City, Town of Washir					10	0d. Inside City Limits 1√2 Yes 2 □ No
h with the	10e. Street and Number 1504 2nd St.	S.W.		10f. Zip Code 20024			10g. Citizen of V		ry?
Maryland 21215-0020 4.2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "retural", or frems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at	11. Marital Status 1 Never Merried 2 Man 3 Widowed 4 Divorced	If Yes Give 7	in U,S.	13. Wes Decedent of Mil Yes, specify Cub		(Specify Yes or No into Rican, atc.)	Bled	e - America ck, Whita, e v:Blac	etc.
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Ball moon in the part of the p	21. Signature of Fundral Service	Kolonson	2	22. Nama end Addre Robinson Wash.	n Funer D.C. 2	al Homo	e 1313	6th	St. N.W.
Physician /Medical Examiner	Immediate Cause (Final disasse or condition resulting in death)	a.	to (or as a co	End 5		ac or respiratory e	errest,		Approximate Interval Between Onset end Deeth
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UIVISION C tall or Attending P us after death. nal Director: After ti lied in by the funera	3 Sulcida 6 Could determ	building, etc. (S)	pecify)	s, street, fectory, office		City or To	Street and Numb wn, Stete)		
To the Hospital or / within 24 hours after to the Funeral Direction pompletely filled in b		g Physician: To the best of my Examiner: On the basis of examend manner steted.	knowledge, ominetion and/o	leeth occurred at the ti or Investigation, in my o	opinion, deeth oc	ce, end due to the curred at the time,	cause(s) and me date and place, 29d. Date signe	and due to	tha cause(s)
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State of Maryland / Department of Health and Mental Hygiene

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/Medical	Shirley Loui	se Mo	ore			July	28, 1	999 11	:55 p
Examiner	4a Facility Nama (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death	
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neral ector	215-46-4590	7. Aga (In y)	rs. last birthday) Yrs.	Months D	Yaar If Under 24 Hrs Days Hours Min.		v. Year)	9. Birtholace (Country) Maryla	
dat "	Usuat Rasidanca of Decedant 10a. Stata 10b. County	10c. (City, Town or Lo	cation					side City Li
zee-i notifie	Maryland Prince G	eorge's	Нуа	ttsvil				118	Yes 2
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To B	19a. Informant's Name/Ratationship (Ty	J	10h Maisin	n Address /C	Street and Number or R				1
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ž	Gloria E. Moore -		Place of Dispos	-	Street, La	Data Data		20706 City or Town, St	late
lary or o	1 Burial 2 Acramation 3 R 4 Donation 5 Other (Specify)	lamoval from Stata	cemetery, crem	atory or othe	r place)	07/29/99		dria, Vi	
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sician	23a. Part1. Entar tha disaase, or compli shock, or haart faitura. List only or	ications that ceused tha da na cause on aach lina.	ath. Do not ente	er the moda o	f dying, such as cardia	c or respiratory an	rest,	Inten	eximate ral Betwee t and Dear
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should be d						24a. Was a perfor	an autopsy med?	24b. Were au available completi	topsy findi prior to on of caus
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State of Maryland / Department of Health and Mental Hygiene

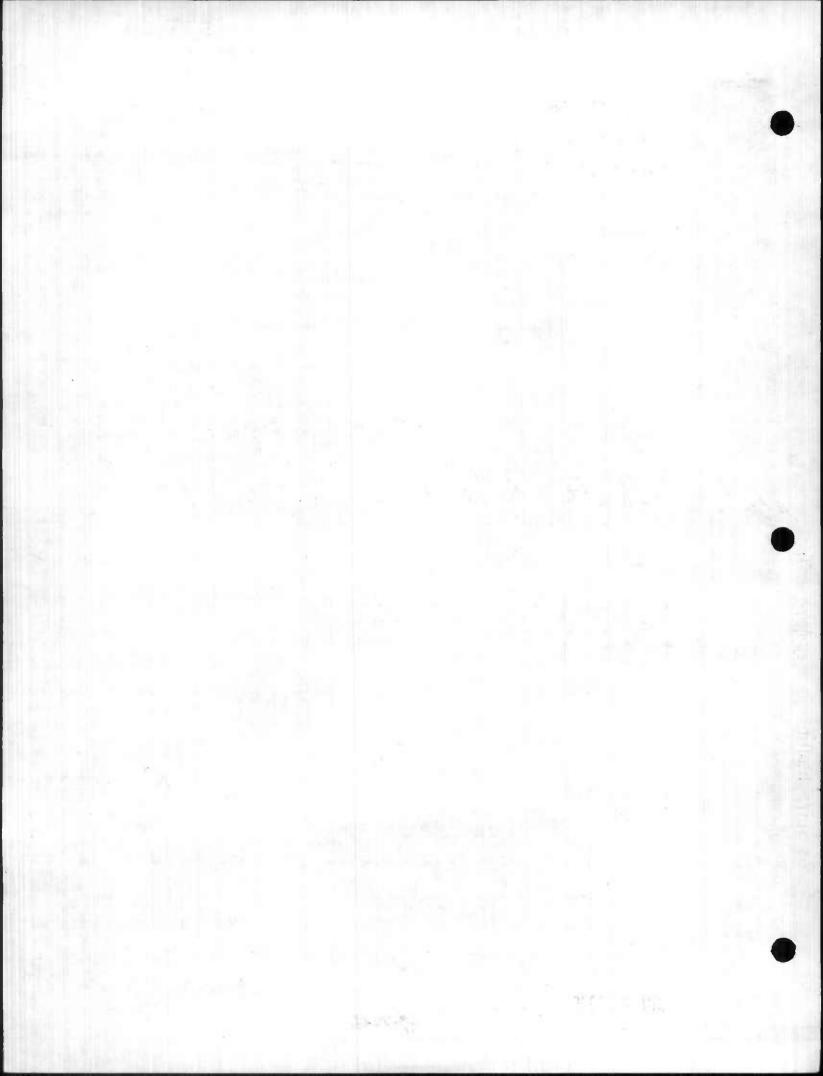
			Ce	rtificat	e of	Death		Reg. No.	6	5418
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/Medical						4b. City, Town, or			99	9:45 AM
Examiner	4a Facility Name (If not institution, giver Prince George's		Conton				Location of Death			ngole
Funeral	5. Social Security Number 6. S	-	In yrs. last birthday)		r 1 Yeer		8. Date of Birt (Month, Da	Princ		ace (State or Foreigny)
Director	579–46–2568 Usual Residence of Decedent	□M 2 ⊠ F	63 Yrs.	Months	Deys	Hours Min.	May 26	,1936	Alaba	ma ma
Du a	10a. State 10b. County	1	Oc. City, Town or Lo	ocation					10	d. fnside City Limits
r 28a-f show	Maryland Prince	George's	Upper N	larlbo	oro					1 X Yes 2 ☐ No
or 28s	10e. Street and Number	-	- ' '	10f. Zip				10g. Citizen of \	What Count	ry?
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or hema marries m by Fune	11. Meritel Stetus 1 2 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				dispenic Origin? (S an, Mexicen, Puer Specify:	specify Yes or No to Ricen, etc.)	Blad	e - America ck, White, e v: Blac	tc.
"natural", pd cal Erro leted by	15. Decedent's Ed	ducation	16a. Dece	dent's Usu	al Occup	pation	1.6-	16b. Kind of B	usiness/Indi	ustry
ygiene. Nor than "natura It, the Medical Completed	(Specify only highest green Elementery/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retire	during most of wo d)	rking			
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and Mental Hygi is marked other eumetic event, To Be Co	17. Father's Name (First, Middle, Last, Claude Murray					18. Mother's Na Cather	ne <i>(First, Middl</i> e, ine Lev		10)	
I Health and Mer tem 27 is marke other treumetic	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address	s (Street	end Number or R	urel Route Numbe	er, City or Town,	State, Zip	Code)
4 Z Z	Claude Murray /Bi	rother	1311	Madi	son	Street,	N.W, Was	shingtor	, D.C	. 20011
nt of Health If Rem 27 or other tr	20a. Method of Disposition 1 🛭 Burial 2 🗆 Cremation 3	Removal from State	20b. Place of Dispondence Commetery, cre	osition (Ner metory or o	me of other ple	ce) Park	07/29	20c. Location		
rtment njury	4 Donation 5 Other (Specification of Superal Sequine Lines					i	1999	Landov	er, M	aryland
permit. Pages Department of t Important: if the any Injury or of	23a. Part1. Enter the disease, or comshock, or heart feilure. List only	. Percent	· J	474 L	JEN and	ss of Facility KINS FUNI over Road	d. Lando	ver. Ma	rvlan	d 20785
death certificate be associted to a second of the second o	disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	b. Breeze	ue to (or as a conse	quence of):	ce	nor	na	_		
	resulting In death) Last	d								
	Pert II. Other algnificant conditions of	ontributing to death but i	not resulting In the u	nderlying o	ceuse gh	ven in Part I.	23b. Did		ntribute to	the cause of death ably 4 Unknow
should should								an autopsy med?	ava	re autopsy findings ilable prior to appletion of ceuse leath?
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ding Phy h. After this funeral c	27. Manufer of Death Naturel 5 Pending Investigation	28a. Date of Injury (Month, Day Y	28b. Time o		28c. Inju Wo		1	now injury occur		
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Funeral Petaly fille	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Check only one) Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.									
Me the	29b. Signature and title of certifier			29	c. Licen:	se number	12	29d. Date signe	d (Month, L	Year)
7	1/16 faren M.D 1303/8 7/23/99									
6	30. Name and address of person who dames Catave	completed cause of dea	th (Item 23a) (Type,	Print)	riv	Chever	olv Man	rland 20	1795	1
State	31. Date filed (Month, Dey, Year)	32t Registrar's		1	1 1 7 6	-, onever	·y , riar	ranu Zu	000	



State of Maryland / Department of Health and Mental Hygiene

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resulting in death)	Last	d	552 10 10	, as a sortion	9001100 01						
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25. Was casa rafar	rad to medical						26. Placa of Dea	ith (Check only or	ne)		
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29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	niner: On the basis	of axamine	owledge, deatletion and/or in	h occurred vestigatio	d at the time n, in my op	e, date end place inion, deeth occu	, end due to the c rred at the time, o	ause(s) and ma late and place,	anner as sta and due to (ited. the cause(s)
29b. Signatura And	titla of certifier				25	c. License	number		29d. Data signe	d (Month, D	lay, Year)
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Rubin Mullins



Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 620AM Mary Joan Novak 1999 JULY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De Examiner BURNIE A

8. Dete of Birth
O8-26-21 OSPITAL

7. Age (In yrs. last birthday) GLEN If Under 24 Hrs. ARUNDEL ANNE RUNDEL If Under 1 Year 5. Social Security Numb 6. Sex Birthblace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours 284-12-5503A 77 Months Director Ohio **Usual Residence of Decedent** 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits mest be notified at 1 Ves 2 No Director Anne Arundel Md. Crofton 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1676 Fallowfield Court 21114 US Norms 23a Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours eler of Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or item eny injury or other treumatic event, its Medical Examples Armed Forces?

1 Yes 20 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 1 Yes 21 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Leo J. Shaughnessy Mary Ellen McNellis 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilbur P. Novak-husband 1676 Fallowfield Ct., Crofton, Md. 21114 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 07-25-99 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA. 21. Signature of Funeral Service Ligation 22. Name and Address of Facility 1 Beall Funeral Home Robert G. Beall -M000256512 N.W. Crain Hwy., Bowie, Md 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MONIZ Examiner Examiner NOV oepital or Attending Physicien: The law requiras that the daeth certificeta be executed hours after deeth. physician and the burlat-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical 987 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Onknown Division of Vital Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1,2 Inpatient 2 ER/Outpatient 3 DOA ship. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After to d in by the funera 1 Natural 2 Accident 5 Pending 1 TYes 2 TNo 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b 11 Cortining Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my colored death. 29a. Certifier iner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

NOVAK, MARY

State Registrar JUL 2 6 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHREIBFERER 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

UNDIEL HOSDIFAL

State of Maryland / Department of Health and Mental Hygiene

		State of Marylar	Certific			Re	g. No.	9 9	5101
Physician	Decedent's Name (First, Middle, Las JANE ELIZ					2. Date of Death Month	Dey	Year	3. Time of Death
/Medical	4a Facility Name (If not institution, give	ABETH NAIRN			4b. City, Town, or Lo	JULY	27, 1	999	10:50PM
Examiner	MANOR CARE HEALTH						P		V
Funeral	5. Social Security Number 6. Se			nder 1 Year	CHEVY CH	8. Dete of Birth (Month, Dey,		9. Birthol	I ace (State or Forei ry)
Director	578-76-3053	□M 21XF 57	Yrs. Mont	ths Days	Hours Min.	9-27-4	1	Trin	idad
anylend ahow	10a. State 10b. County		ty, Town or Location					10	d. Inside City Limit
vith the Mar t or 28a-f a be notified Director	MD. Montgome	ery (Chevy Chas			1.0			1 Yes 2□N
with the	8700 Jones Mill:	s Road	107.	Zip Code	-	10	g. Citizen of V		ry?
ifter death v r items 23e olost must Funeral	11. Marital Status	12. Was Decedent Ever in U	I.S. 13. Was Do	2081 ecedent of F		ecify Yes or No-	U.S./	A . e - America	in Indien,
y y	3 🛱 Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:	100	specify Cubes 2 No	tispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)		k, White, e	
	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. Decedent's U (Give kind of life. DO NO	work done	during most of worki	ng 1	6b. Kind of Bu	sinass/ind	ustry
Hiled within Hygiene. ther then mit, the Man	Elementary/Secondary (0-12)	College (1-4or 5+)	Nursing				N/A		
D STATE OF THE CO	17. Father's Name (First, Middle, Last)				18. Mother's Neme			(e)	
Mar y lattic d 2 should be file h end Mentel Hy 7 is marked other reumatic event To Be C	Reeves Louis 19a. Informant's Name/Relationship (7)	ome (Print)	10h Mailing Add	enen /Ctroot	DOII	y Arnold		State 7in	Codel
C = N L	Thelma Alfred/Sis				Drive, Si				
Dallimore, semit. Pages 1 ar Seperant: If Nem moutant: If Nem in Injury or other total.	20a. Method of Disposition 1 X Burial 2 □ Cremetion 3 □ f		Place of Disposition (Name of or other place	ce)	Date 2	Oc. Location -	City or Tov	vn, State
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pemit. Page Depertment of Important: If eny Injury or pngs.	21. Signature of Funeral Service Licens	Hacket &	Hac	kett'	ss of Facility S Funeral hur Stree		Inc.		
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To the Hopital or Attending P within 24 hours alser dealh complately filled in by the funer Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		ctory, office		281. Location (Str City or Town,		er or Rurai	Route Number,
n 24 houn n 24 houn ne Funera plately fillig		eiclen: To the best of my kno ner: On the basis of examina and manner stated.							
within To the	29b. Signature and title of certifier	0 1:		29c. Licens	se number	29	d. Date signe	d (Month, L	Day, Year)
	> Ellen ml	inhalt m	D	DS	51015		July	1 2	8 1999
(2)	30. Name and address of person who or EUEN PINHOL		n 23a) (Type, Print) 30 Wisc	nsia	Ave Sui	tz # 104			
State Registrar	31. Date filed (Month, Day, Year) JUL 2 9 1999	32. Registrar's Signa	ature	•)	

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AMEND ITEM	#23 PART I, PER MD G774	State of Maryland 8-27-99 WR.		tment of H			giene 99	25122
	1. Decedent's Name (First, Middle, Last,					2. Dete of De	eth	3. Time of Death
Physician	Pohont Dudlov	Orom				July	24 199	99 9.40 AM
/Medical Examiner	Robert Dudley 4e Fecility Neme (If not institution, give	street and number)		4	b. City, Town,	or Location of Deat		
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P .	Usuel Residence of Decedent 10a. State 10b. County	100 City	, Town or Local	tion				10d. inside City Limits
anyla sho	2000	Too. Ony						1 √2 Yes 2 □ No
Pect Seed	Maryland Kent 10e. Street end Number		Cnes	tertown 10f. Zip Code			10g. Citizen of Wh	Λ
Die Be				2162	20		United St	
s 23	415 Morgnec Road	12. Was Decedent Ever in U,S	13 We			(Specify Yes or No		American Indien,
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiene. T is marked other than "natural", or items 23s or 28s-1 show traumstic event, the Medical Eurober must be nound	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates: Unk		7.7	Specify:	(Specify Yes or No erto Rican, etc.)	Black,	White, etc.
2 hou	15. Decedent's Edu	cation	16a. Deceder	it's Usuel Occup	ation		16b. Kind of Busin	
Maryland 21215-0020 do 2 should be filed within 72 hours af the and Mental Hygiene. The marked other than "natural", or traumatic avent, the Medical Exercity of To Be Completed by F	(Specify only highest grade Elementary/Secondary (0-12) 12	Coilege (1-4or 5+)	(Give kir life. DO Inspe	d of work done of NOT use retired	furing most of (working	Roads & 1	Bridges
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short and h	19a, Informent's Name/Relationship (Ty	pe, Print)	19b. Mailing	Address (Street	and Number or	Rural Route Numb	er, City or Town, St	ate, Zip Code)
Baltimore, Me permit. Peges 1 and 2 to Department of Health and Important: if Item 27 is any Injury or other trau page.	Ida Ann Orem Camp 20a. Method of Disposition	20b. Pi	ece of Disposit	lemans I		udlersvil	le, Mary	land 21668 ity or Town, State
Pege mi: if ny or	1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emoval from State Chesar	peake Cre	mation Ce	nter, W	C. 7/28/99	Stevensvill	e, Maryland
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O. I on the shift hed the shif	Part II. Other significant conditions con	tributing to death but not resu	lting in the unde	erlying cause giv	en in Part I.	23b. Did	tobacco usa contr	ribute to the cause of death?
IS, P.O. es that the de igned by the a be deteched iby Physical by	HTN, S/PCVA®	Hemipores A	phasia	CAD,	- ,	1 🗆	Yes 2□ No 3	3□ Probably 4₩ Unknown
If Records, P.O. Box 68760, The law requires that the death certificate be executed tale has been signed by the attending physician and page 2 should be deteched for use as the burial-transic Completed by Physician/Medical Exami	P.V.D. , S/O BAK						en autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
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	30. Name and eddress of person who co	4	23a) (Type, Pri	Int)		wn MD	21677	,
-64-46	31. Date flied (Month, Day, Year)	32. Registrar's Signat				CON FID	-1620	
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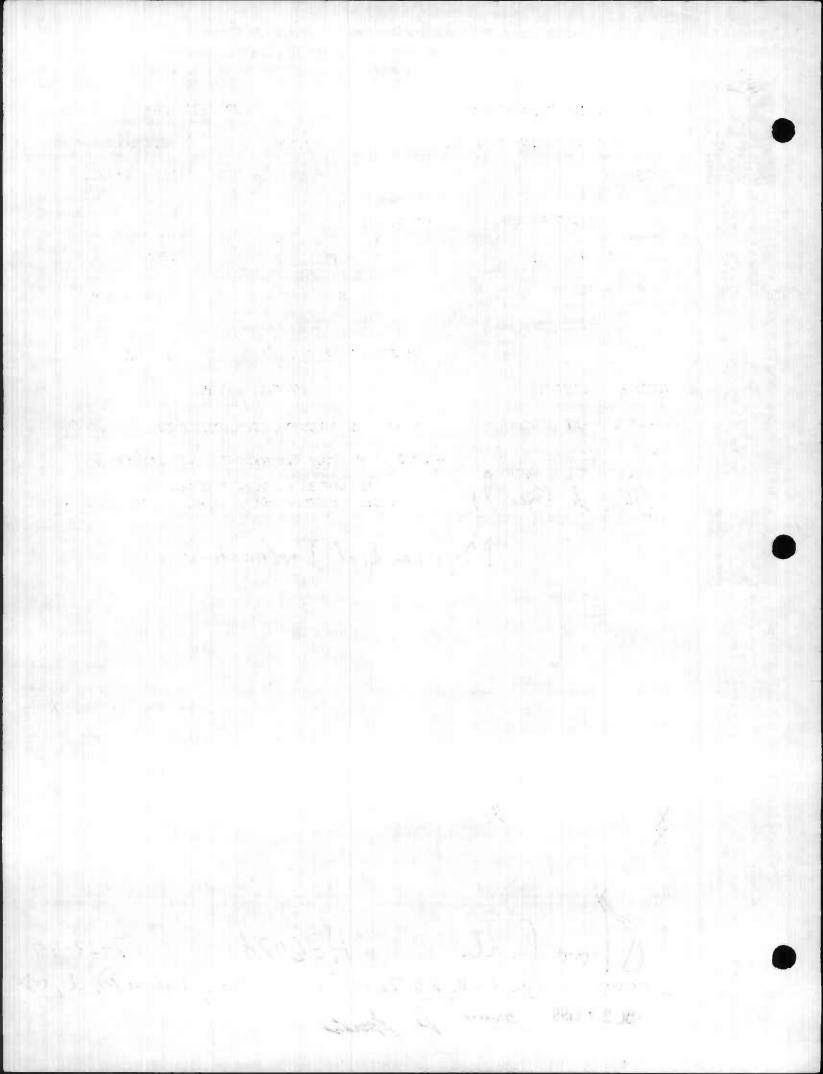
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1999 July 1:51 pm /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Deys Hours Min. Yrs. Director 236-58-7661 60 Aug., 16, 1938 Tams, West Va. Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic avent, the Medical Experiment mant be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yas 2 No Prince George's Upper Marlboro Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9310 Grandhaven Avenue 20772 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind at Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher P.G. Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Fannie Odessa Coleman Walter T. Snyder 19a. Intermant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9310 Granhaven Ave., Upper Marlboro, MD 20772 Ian Pearis/Husband 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 7-28-99 Cheltenham, Maryland Veterans Cemetery 21. Signature at Funeral Service License 22. Name and Address of Fecility Alexander S. Pope Funeral Homes Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert tellure. List only one ceuse on each line. 5538 Marlboro Pike, Forestville, MD 20747 Approximete Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) CAMIDICIPINATOR Examiner Examiner FVACTORY attending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last INFAMCTOU! Box 68760. Awt My O Cann A death certificate be Physician/Medicai 98 ed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, à 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed paga 2 s has certificate 1 Yes 2010 1 ☐ Yes 2 ☐ No 25. Wes care reterred to medical examiner? or Attending Physician: Be 26. Piece of Deeth (Check only one) 1 Yes Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 70 this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how Injury occurred 28b Time of 28c. Injury et Work? Certification: After 1 Neturel 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner as steted. 29a. Certifier edicai completely 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated. (Check only To the Vithin 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ot death (Item 23a) (Type, Print) ss of parson who 0 30. Name and audie 20735 Scott Kelso, M.D. 7503 Surratts Rd. Clinton, Maryland 31. Dete tiled (Month, Day, Year) 99 Registrar's Signature State Registrar



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Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 1830 Margaret Elizabeth Ray JULL 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Union Hospital of Cecil County Elkton Cecil 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. 6 Sex 9. Birtholace (State or Foreign 8. Date of Birth (Month, Day, Year) Deys 1□ M 2X F Months Hours -Maryland Yrs. 216-24-5089 December 10, 1926 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d, Inside City Limits Maryland Cecil Elkton 1 ☐ Yes X☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 55 Knight 21921 Cornor Road United States 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 Domestic House Keeper | House Keeping 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Donald Garnett Elsie Braxton 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Richard Albert Ray - Son 147 Knight Cornor Road, Elkton, Maryland 21921 20b. Place of Disposition (Neme of comeleny, cremetory or other place) August 3, 1999 20c. Location - City or Town, State Mary Land 20e. Method of Disposition Burlel 2 Cremetion 3 Removel from Stete Bohamia Manor Cemetery Chesapeake City, 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licani reliows, Helfenbein & Newnam Funeral Home, P.A. William L. 226 East Main Street, FO Box 342, Cecilton, Maryland 21913 dr. King 23a. Part1. Enter the disease, or complications that caused in death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or hear fellure. List only one cesses and the contract of Approximate tntervel Between Onset and Death (MRSA, VRE Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es e consequenca of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes OFTNO 1 Yes 2 No 25. Wes case referred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 (1) Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred

Physician /Medical Examiner

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certificate

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After

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To the Hospital or within 24 hours at To the Funeral D

Hospital or Attending Physician:

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requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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7 is marked other than "natural", or items 23s or 28s-f ahow traumatic event, the Medical Examiner must be notilled at

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death

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itement injury or other trauments.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but got resulting in the underlying cause given in Pert I.

1 Yes 2 No 27. Manner of Deeth

5 Pending investigetion 6 Could not be determined 28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Neturel

2 Accident

3 Suicide

4 Homicide

1 👺 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

29b. Signature and this of certifier

29c. License number 044716

29d. Date signed (Month, Day, Year)

Toke Ma. M.D.

30. Nemy and address of person who completed cause of death (Item 23a) (Type, Print) Union Hospital of Cecil County, Elkton, MD

State Registrar 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signeture AUG 02

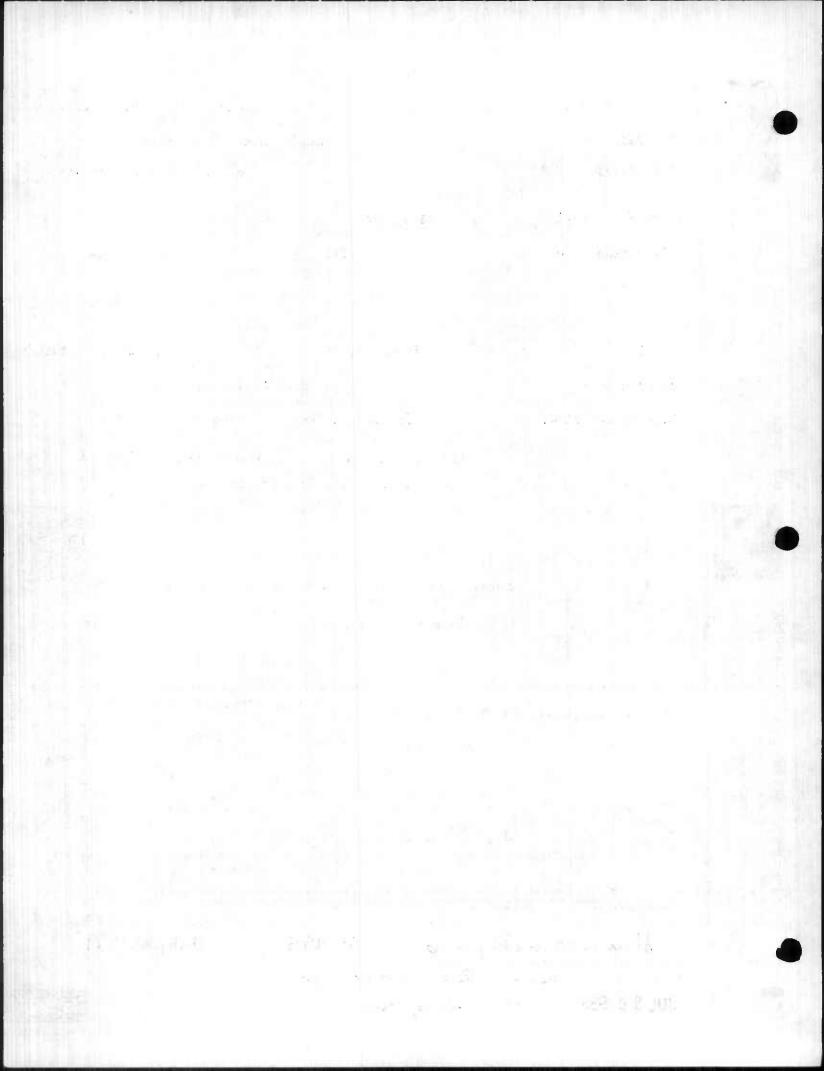
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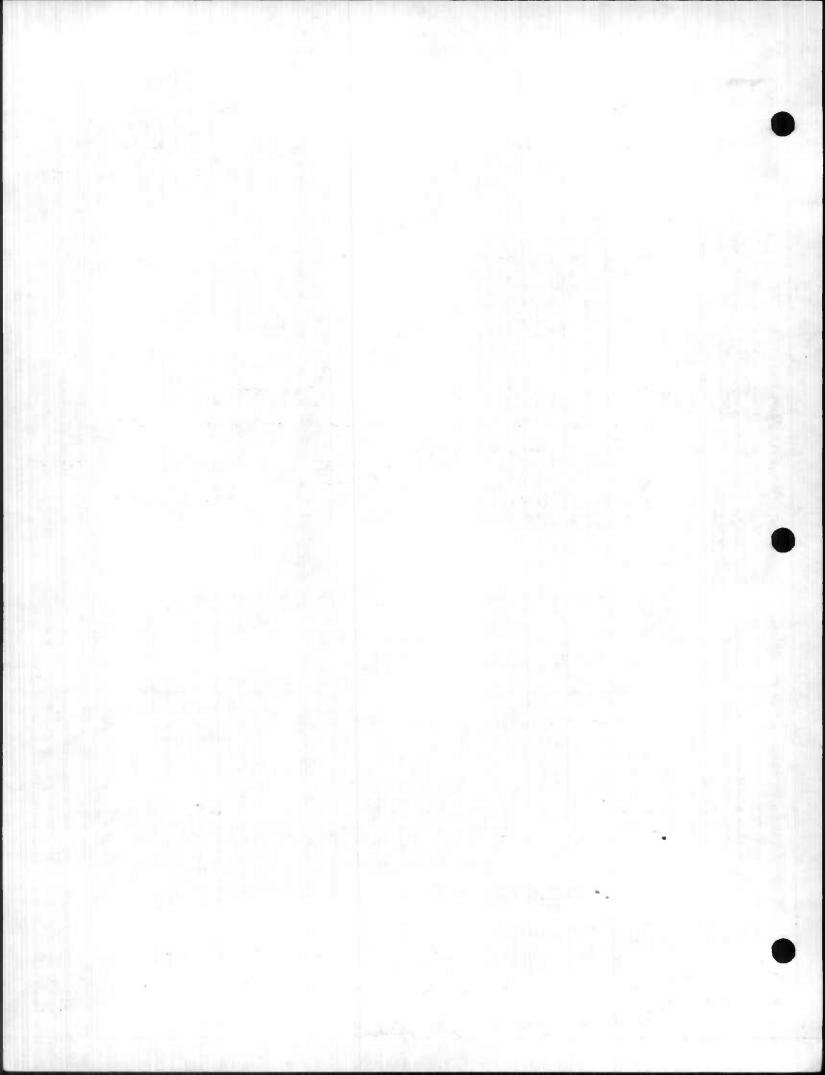
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State of Maryland / Department of Health and Mental Hygiene

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dS, P.O. BOX 6 iries that the death certifi signed by the ettending d be detached for use as d by Physician/Me		d						1	
dead dead dead dead dead fo	Part II. Other significant conditions of	ontributing to death but n	ot resulting in th	na underlying causa giv	ven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
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S, Fe se the gard of the de de de de de de de de de de de de de	/ Metastati	Jung	9 (a	nces					
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Ing Find Find Find Find Find Find Find Find	27. Manner of Death 1 Natural 5 Pending	28a. Data of Injury (Month, Day Y	ear) 28b. Tim Inju	ry Wor		28d. Describe	how injury occur	red	
VISION Attending or death. ector: After by the fune	2 Accident invastigation 3 Sulcide 6 Could not be			M 10	Yas 2□No				
Division of birds of the control of	4 Homicide detarmined	28e. Place of Injury building, etc. (3	 At home, fem Specify) 	, street, factory, office		28f. Location (City or To	Street and Numb wn, Stata)	per or Rural	Route Number,
O Seine									
n 24 hound no 24 hound no 54 h	29a. Certifier 1 Certifying Ph	ysician: To the best of mainer: On the basis of ex	ny knowledge, d	eath occurred at the ting	me, date end place	, and dua to the	cause(s) and ma	ennar as sta	the cause(s)
12 T 2 -	one)	and manner steted	I.	i ilivastigation, at my o	pillon, death occu	ned et the time,	date end place,	and dua to	uia causo(s)
\$: \$ d	Look Otherston and Mile of control			29c. Licans	se number		29d. Data signa	d (Month, E	Day, Year)
Division of Vital Re To the Hospital or Atlanding Physicien: The I within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29b. Signatura and titla of certifier				-		11	1 6	
To the within 2 To the complex	290. Signatura and tria of certifier	Alma.	un	17).	5 4/5		10	1-49	7
	30. Name and address of person who	completed cause of deat	10 (Item 23a) (Tv	pe, Print)	5 915		80	1-99	7
To the within 2 To the complet	30. Nama and addrass of person who	A D	h (Item 23a) (Ty	pe, Print)	15 ch S	24 - 56	te 310	E14.	ton MD.
5	Barbara	completed cause of post	MD	pe, Print)	High S	34 - Sú	de 310	EIK	
	30. Name and address of person who Barbara	A-Parey	MD	pe, Print)	High S	34 - Sú	de 310	EIK	ton, MD. 21921



State of Maryland / Department of Health and Mental Hygiene

		Otate of Mai	ylaria / i	Certificate		and mor	, ,	g. No.	_	25428
	1. Decedent's Neme (First, Middle, Las	st)				2.	Dete of Death		Many	3. Time of Death
Physician	DIANE RO	BINSON				J	Month ULY 22	.1999	Yeer	7:50am
/Medical Examiner	4a Facility Name (If not institution, give	e street and number)			4b. City, To	wn, or Locati		4c. County	of Death	
Examine	737 MAURY AVE	APT 106			OXON	HILL		PRINCI	E GEO	RGES
Funeral Director	5. Sociel Security Number 6. S	ex □M 2 ¹ F	(In yrs. lest bii 42	rthdey) If Undar 1 Months I		24 Hrs. 8. Min.	Date of Birth (Month, Dey, 1)	Year) 5.1957	9. Birthp Coun Wash	lace (State or Foraign try)
p	Usuel Residence of Decedent									
how	10e. State 10b. County		IOc. City, Tow	n or Location					- 1	0d. Inside City Limits
o Me	Maryland Prince Ge	eorge's	0xo	n Hill						1⊠Yes 2□No
or 2	10e. Street and Number			10f. Zip Co	ode		10	g. Citizen of W	/hat Coun	try?
th with the Maryler 23a or 23a-f show ut be notified.	737 MAURY AVE APT	#106		2074	3			UNITED	STAT	ES.
2 should be filed within 72 hours after death with the Maryland end Mental Hygiene. Is marked other than "natural", or itams 23a or 28a-f show reumstic event, the Medical Experient must be notified at To Be Completed by Funeral Director	11. Marital Status 1 ☼ Nevar Marrled 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Dates:		13. Was Deceden If Yes, specify	t of Hispenic Or Cuban, Mexical No Specify:		Yas or No- an, atc.)	Black	- Amaric k, Whita, Blac	
"natural",	15. Decedent's Ed		160	. Decedent's Usuel C	Occupation	4 44	11	8b. Kind of Bu	siness/Inc	dustry
led within 72 ho yegiene. ner then "nature it, the Medical Completed	(Specify only highast gre	de com <i>pleted)</i> College (1-4or 5+)		Decedent's Usuel C (Giva kind of work of life. DO NOT use	retired)	t of working				
d wit	Elementery/Secondary (0-12)			Security G	uard		Private			
be file d other event	17. Father's Neme (First, Middle, Last)				18. Moth	er's Neme (Fi	irst, Middle, Mi	e <i>id</i> en Su <i>m</i> em	e)	
Menta Menta Prked Stic e	Fred Robinson				Min	nie R	ichard	S		
shot s and h	19e. Informent's Neme/Reletionship (Type, Print)	196	o. Mailing Address (S	itreet end Numb	er or Rural R	oute Number,	City or Town,	Stete, Zip	Code)
and 2 baith e n 27 le	Minnie Robinson/	Mother	45	09 3rd St	. S.E.#	A Wash	ington	, D.C.	200	32
s 1 a f Heat f Heat othe	20a. Method of Disposition	NO CHICL	20b. Plece o	of Disposition (Nema	of colocal		Date 2	0c. Location -	City or To	wn, Steta
Pages nent of international	1 ABuriai 2 Cremation 3 ☐ 4 Donetion 5 ☐ Other (Specification 5 ☐ Other (Specification 2)					17/2	9/99 T	andover	- Md	
ofur P	21. Signeture of Funerei Service Licen		пагшоп	y Memoria	Address of Facili		0/33 15	andover	, priu .	
permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental hygiene. Important: If Itam 27 is marked other than "naturaly injury or other treumatic evant, the Medical and Injury or other treumatic evant, the Medical and Injury or other treumatic evant, the Medical and Injury or other treumatic evant, the Medical and Injury or other treumatic evant, the Medical and Injury or other treumatic evant, the Medical and Injury or other treumatic evant, the Medical and Injury or other treumatic evants.	1/ 10	4		Alexand	er S. P	ope Fu				
	Keth G. Sar	Ea M1085		5538 Ma	rlboro	Pike/F	orestv	ille, N	1d.	20747
	23e. Pert1. Enter the disease, or comp shock, or heart feilure. List only	plations that caused the	ne deeth. Do	not enter the mode of	of dying, such es	cardlec or re	spiretory erres	st,		Approximate Intervei Between
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The law ata hes be page 2 s										déath?
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certificate rector, pag	25. Wes case referred to medical examiner?	Hospitel:			Other:		theck only one			
this caldire	1 Yes 2 No	1 L Inpatient			4 LIN			nce 8 DOth		у)
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DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

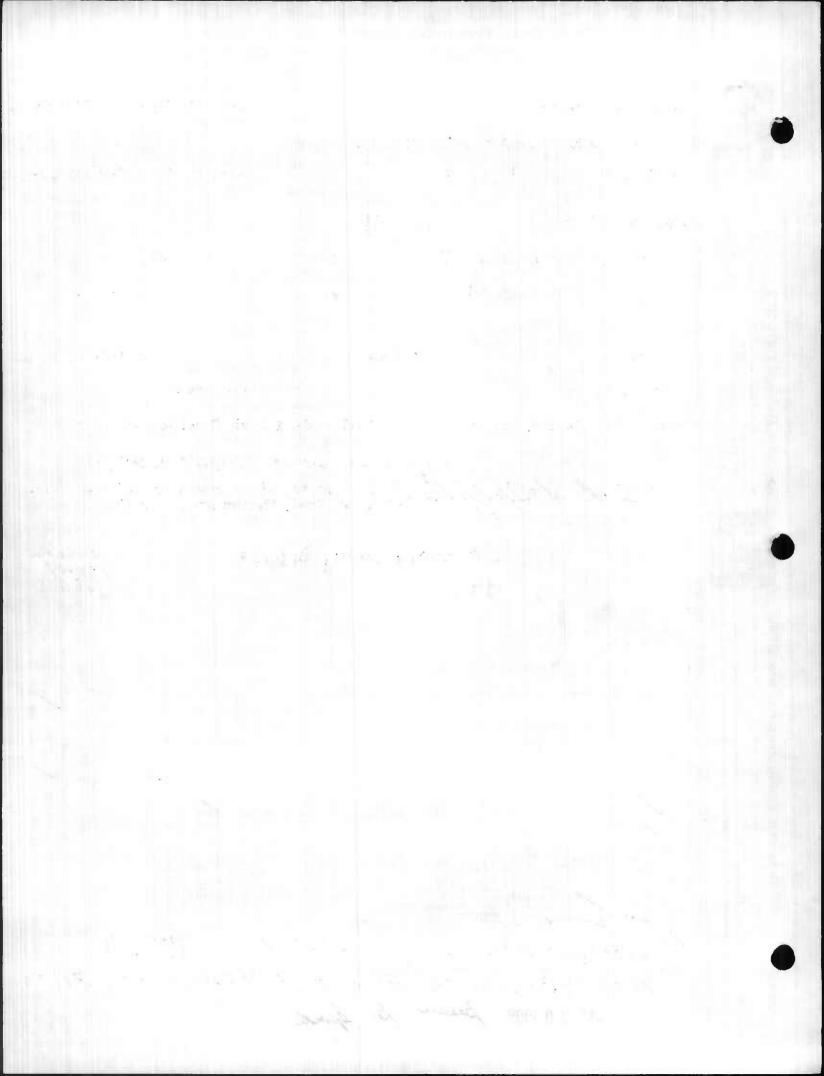
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Physician Medical Examiner Part Enter the disease_compleciplons that cause the death. Do not enter the mode of dying, such as cerdac or respiratory arrest.	Imor	Pages I mant of h ant: if he uny or of	1 ☑ Burial 2 ☐ Cremetion 3 ☐ F	Removel from State	cemetery	, crematory or other pla					
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230. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown 24s. Was an autopsy performed?	X DB	ding phy			o (or as a co	insequence or):					
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25. Wes case referred to medical axaminer? 26. Place of Death (Check only one)	j.	by the tached	Part II. Other significant conditions con	ntributing to death but not	resulting in	the underlying ceuse gi	ven in Part I.				
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25. Wes case referred to medical axaminer? 26. Place of Death (Check only one)	ř	The its he cage						10	Yes 2 No	10	Yes 2□ No
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Dr. Suresh Patel Southern Marylnad Professional Bldg. #307 Clinton, MD State 31. Date filed (Month, Day, Year) Registrar's Signature		(6)	30. Name and address of person who co	impleted ceuse of death (Item 23a) (T						
State 31. Date filed (Month, Day, Year) 39 Registrar's Signature		E					nal Bldg.	#307	Clir	ton.	MD
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State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificat	e of	Death		Reg. No.	2 6	0431	
Division.	1. Decedent's Neme (First, Middle,	100					2. Date of Death Month Day Year 3. Time of					
Physician /Medical	IRUI ALLEN SCUII								July 24, 19		8:05 A.M.	
Examiner	a me and a man and a man a man a man a man a man a man a man a man a man a man a man a man a man a man a man a				4b. City, Town, or			n, or Location of Dea		y of Death		
	4711 Bromley Avenue Suitland							Prince George				
Funeral	5. Social Security Number	S. Sex	7. Age (In yrs. I				Hours 4		irth	9. Birthp	Birthplace (State or Foreig	
Director	578-96-0068	1 ∑ M 2□F	F 31 Yrs.					MARCH	MARCH 9, 1968		WASHINGTON DO	
9 .	Usual Residence of Decedent											
abon da	10a. Stete 10b. County 10c. City, Town or Location									1	0d. Inside City Limits 1 Yes 2 No	
or 25s-f show a notified at	MD PRINCE GEORGES SUITLAND											
with the Ma tor 28arts be notified Director	10e. Street and Number		10f. Zip Code					10g. Citizen of What Country?				
ther death v						20746			UNITED STATES			
	11. Maritai Status	Armed F	Armed Forces? 1 ☐ Yes 2 ② No If Yas, Giva Year or Dates:			 Wes Decedent of Hispanic Origin? (Spot Mexican, Puerto 				14. Race - American Indian, Bleck, White, etc.		
	1 Never Married 2 Merrie	If Yas, Gi				2 🔯 No	Specify:		Specif		y: BLACK	
hours of the state												
ed within 72 ho yglene. ner then "nature it, the Medical.] Completed	15. Decedent's (Specify only highest		16a. Decedent's Usuat Occupation (Give kind of work done during most of wo				of working	orking 16b, Kind of Bus		lustry		
William Man	Elementary/Secondary (0-12)	College (College (1-4or 5+)		life. DO NOT use retired)				NT / A	N/A		
Dar O	8 17. Father's Neme (First, Middle, Li	net)			DISABLED 18 Mother's A			s Name (First, Middle	1			
Be see		•	T					TTERSON				
should on Men marke amaric	19a. Informent's Name/Relationshi			40h Maiti		- /Ctt						
10 中華	SAPHRONIA SCOTT		SISTER		_				ural Route Number, City or Town, State, Zip Code) UITLAND, MD 20746			
	20a. Method of Disposition	DICARLE)		lace of Disposition (Name of					Date 20c. Location - City or Town, State			
semit. Pages 1 a Department of Hea reportant: if lism inty Injury or othe Acce.	1 ☐ Burial 2 🖾 Cremation 3		State cemetery, cremetory or			other plac						
artmer ortant Injury	4 Donation 5 Other (Spe		(CHESAP				7-30-99	7-30-99 BELTSVILLE,MD			
Departitude of the control of the co	21. Signature of Fungral Service Incorporation (22. Name and Address of Facility ALEXANDER S. POPE 1							PE FUNERA	L HOME			
00260	5538 MARLBORO PIKE, FORESTVILLE, MD 20747											
	23a. Part1. Enter the disease, or complication of a faused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate the respiratory arrest, shock, or heart tailure. List only one cause on each line.											
Physician	Onset and Deeth											
/Medical	Immediate Cause (Final disease or condition Cardina Usmortmohy)											
Examiner	disease or condition resulting in deeth) a. Cardiac Hypertrophy Due to (or as a consequence of):											
e = c	Morbid Obesity and Hypertensive Cardiovascular Disease											
entiticate be executed ling physician and as the buriet-transit	Sequentially list conditions,	011020		as a consec			210170	Cararoval	Carar D.	ZDCGD.		
ficate be exe g physician a as the burial-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									1		
he by	Cause (Diseese or injury that initiated events resulting in death) Last	Due to for es a consequence off:								1		
25 OI 0 02	resulting in death) Last									- 1		
		d								i		
0 0 0 0	Pert II. Other algnificant conditions	s contributing to d	eath but not resul	Iting in the u	nderlying o	ause giv	ren in Pert t.	23b. Did	tobacco use co	ontribute to	the cause of death	
t the by the tach	Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert t.						10	1 Yes 2 No 3 Probably 4 X Unknow				
as tha igned be de												
v requires that the been signed by th should be detache leted by Phys								24a. We			ara autopsy findings	
he law requiras to has been signe to a should be completed by									performed?		available prior to completion of cause of death?	
The law require cate has been single 2 should Completed								100	Yes 2□No	10	¶Yes 2□ No	
certificate rector, pag	25. Wes case reterred to medicat						OC Disease			1 2	1163 20140	
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4 5 7	27. Manner of Death	28a. Dete		ER/Outpatier 28b. Tima o		JA	4 LI NUIS	-	how injury occu		7)	
Attending Ph or death. ector: After thi by the funeral	Natural 5 ☐ Pending	(Mon	nth, Day Year)	tnjury	м	28c. tnjur Wor 1 □	k? Yes 2 ∐ No		200.200.000.000.000			
death death stor: y the	3 Suicide 6 Could not be 200 Place of Lawrence As Association						28f. Location (Street and Number or Rural Route Number,					
tal or Attanding P is after death. al Director: After tied in by the funers Certification:	4 ☐ Homicide determin		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						City or Town, State)			
ptra	20a Codifice 4 Codifice Physician Toth Special Code											
Ne Hospital n 24 hours Ne Funeral pletely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to											
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	· John Market Glade.							29d. Date signed (Month, Day, Year) July 25, 1999				
F 3 F 8	29b. Signeture and title of certifier											
	Servier J. Cheef. 49				O.C.M.E.							
	30. Neme and address of person wit	no completed caus	se of deeth (ttem	23a) (Type,	Print)							
	Dennis Chute				111 P	enn	Street	, Baltimo	re, Mary	land	21201	
State	31. Date tiled (Month, Day, Year)	9 %	Registrar's Signet	ure	Loon	10	,					
Registrar	JUL 3 0 199	امرا	/	h. /	good	m						

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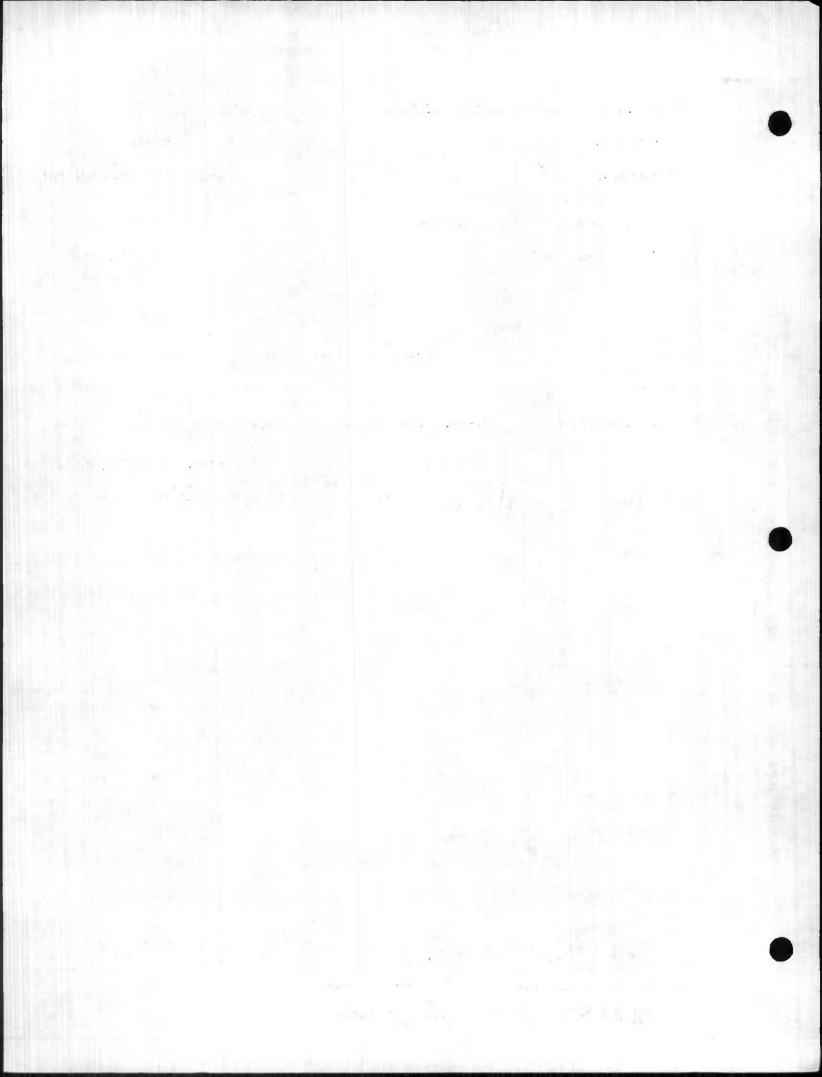
			Certificate of Death						Reg. No. 2. Date of Deeth 3. Time of Death				
П	Physici	an	1. Decedent's Name (First, Middle, Last)							Month Dev 1			
	/Medi		Evelyn Mina Stevens							-1	1999 11:30 a.		
	Examir	ner											
_			5. Sociel Security Number		vrs. lest birthday) If Undar 1 Yaar If Under 24 Hrs. Months Deys Hours Min.				Kent 9 Birthplace (St		niace (State or Foreign		
	Funeral Director		213-16-7191	79							place (Stete or Foreign ntry) stertown, MD		
	land land	tor	Usuel Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location							10d. In			
	Mary Heh		Maryland Ken	t.	Rock Hall							1 Yes 2 □ No	
	r 284	Funeral Director	10e. Street and Number		10f. Zip Code				10g. Citizen of W	/hat Cou	ntry?		
	h wit	aiD	5795 Chesapeake Villa Apt. #21			12 21661				USA			
	Baltimore, Maryland 21215-0020 permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental thypiena. Important: if item 27 is marked other than "naturel", or items 23s or 28s4 show any injury or other traumatic event, the Medical Example motified an DOGS.	ner	11. Marital Status 1 Never Merried 2 Married 2 Wildowed 4 Divorced 12. Wes Decedent Ever Armed Forces? 1 Yes 2 No the Year or Detes:			13. Wes Dece	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yas or No	14. Rece	- Americk, Whita,	can indian,		
020		by				1 ☐ Yes 2 No Specify:			Specify:			nite	
215-0		Completed	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+)			16e. Decedent's Usuel Occupation (Giva kind of work done during most of work) life. DO NOT use retired)				16b. Kind of Business/Industry			
2		EO.	12			Processor				Food Processing			
D		Be	17. Fether's Neme (First, Middle, Last) 18. Mother's Neme						ne (First, Middle, Meiden Surnema)				
yla		2	Louis H. Porte							nce Dodson			
Na			19a. tnforment's Neme/Reletion					t end Number or Rur					
e,	1 and Healt em 27		Paul Leslie St 20e. Method of Disposition	evens, Sr./Sc	20b. Pleca	of Disposition (Ne	me of	msburg Ro	ad, Ste	rling, V			
nor	agas intof in Hit		1 Surlel 2 ☐ Cremetion	3 □Removel from Stete	cema	tery, crametory or	othar pie						
	artme ortan injur	1	4 Donetion 5 Dother (Specify) Wesley Chapel Cemetery 7/31/99 Rock Hall, MD 21. Signeture of Funeral Sergice Licenses 22. Name and Address of Fecility										
ä	Deparition of the parties of the par		Pellows, Helfenbein & Newnam Funeral Home, P.A.										
	Physician //Medical Examiner bulyaician and physician and street being-francial transit at the prival-francial and street bulled transit and street		23a. Pert1. Enter the disease, or complications that daught death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onsat and Death										
			Immediate Cause (Final disease or condition resulting in deeth) e. COR ON ARY ACHO DISCUSE ON MANY Due to (or es e consequence of):										
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			Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying		Due to (or es	e c <i>on</i> sequence of)	:				1		
68760,		ie i	Cause (Disease of Injury										
	E 01-6	-	Due to (or as a consequence of):										
Box	death certifi	Physician/M		d							1		
0	nat the d by the detached	/sic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death?				
σ.		by Phy							1 Yes 2 No 3 Probably 4 Unknown				
Records,	v requira: been sig should b									s an autopsy ormed?	81	Vera autopsy findings valleble prior to	
မိုင္ပ	law re	ple								/		ompletion of cause i death?	
		Completed							10	Yes 2₽No	1	☐ Yes 2☐ No	
Vita	yelcien: The law vis cartificate hes t I director, page 2 s	Be	25. Wes case referred to medic exempler?				0	26. Place of Deel	th (Check only	one)			
o	Physician: rthis cartific inal director,	10 1	1 Yes 2 No 27. Menner of Deeth	Hospitel: 1 tnpatie		Outpatient 3 D	UA			how injury occurr		(y)	
5	Afta fune	tion	1 Neturel 5 □ Pend	28e. Dete of Inju (Month, De stigetion	y Year)	Injury	28c. Inju Wo	ork?] Yes 2 □ No	20d. Describe	now injury occur.	00		
Division of Vital	r Attending lar daath. rector: Aftai	Certification:	2 Accident 3 Sulcide 6 Coul 4 Homicide	ury - At home, c. (Specify)	come, ferm, street, fectory, office 28f				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ω	pital o												
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai	29e. Certifier (Check only one) Contifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.										
	To the To the Committee of the the the the the the the the the the	Σ	295 Signature and 1916 of certif		29c. Licanse number				29d. Data signed (Month, Dey, Year)				
			(sand then ma				D 36054			1130149			
			PRICK S	who completed cause of c	leath (Item 23e	e) (Type, Print)	ree	n Rd C	DE STS	Erom	mo	2/622	
	Sta	te	31. Dete filed (Month, Day, Yea	r) 32. Registr	ar's Signeture		-	- [
	Registr	ar	JUL	3 0 1999	seres -	Ø.	200	all!					



State of Maryland / Department of Health and Mental Hygiene

					(Certifica	ite of	Death		F	Reg. No.	2 6	0400	
		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea	ith		3. Time of Death	
Physicia		Rev. Joseph Edwar	d Staff	ford (OSF	G				July 28	Day 3. 1999	Year	0830	
/Medica		4a Facility Name (If not Institution, giv			0.5.1.			4b. City, To	wn, or Lo	cation of Death	4c. Count		0630	
Examini	21	Annecy Hall						Chile	3.0		Coni	1		
		5. Social Security Number 6. 5	Sex	7 Age (In s	yrs. lest birtho	(av) If Und	er 1 Year			8 Date of Birth	Ceci	_	place (State or Foreign	
Funeral Director			Ø M 2□ F	73	Yr	Months	Days	Hours	Min.	8. Date of Birth (Month, Day June 11			place (State or Foreign ntry) nsylvania	
9 E-	1	10a. Stete 10b. County		10c.	City, Town o	r Location						1	10d. Inside City Limits	
with the Maryland a or 25s-f show the notified at	Director	Maryland Cecil		Ch	ilds								1 ☐ Yes 2 ☐ No	
6 9	듬	10e. Street and Number				10f. Z	ip Code				10g. Citizen of	What Cour	ntry?	
4 52 a		1120 Blue Ball Ro	ad				2191	6			Unit	ed St	ates	
9 85	Funeral	11. Meritel Stetus	12. Was Dec	cedent Ever i	n U,S.	13. Was Dec	edent of F	lispanic Ori	gin? (Spe	city Yes or No- Rican, etc.)	14. Rec	ce - Americ		
OZO OUR S EXM	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		2 ₽ No ive			2 K No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specif			
72 hours	Completed	15. Decedent's Ed			16a. D	ecedent's Us	ual Occup	ation			16b. Kind of B	usiness/In	dustry	
within 7 one. Blan in	용	(Specify only highest gra Elementary/Secondary (0-12)		(1-4or 5+)	(6	give kind of w fe. DO NOT	vork done use retire	during mosi d)	t of workii	ng				
A standard	E	Elementary/Secondary (0-12)	8	(1-401 34)	Teac	her/ (blat	e Pri	est	Religious ne (First, Middle, Maiden Sumeme) 71 ing				
D STREET	Be C	17. Father's Name (First, Middle, Last,)											
d be sed of contain	ToB	Joseph A. Staffor	d					Anna	Dowl	wling				
Maryland d 2 should be file the and Mental Hy 7 is marked othe traumatic event	-	19a. Informant's Name/Relationship (Type Print)		19b A	Mailing Addre	ss (Street			Wling ural Route Number, City or Town, State, Zip Code)				
Me trau		Rev. Francis J. Han		C F C						Wilming				
e, N Health Health Char tr	-	20e. Method of Disposition	11011, 0		b. Place of D			Parky	vay,	Date	20c. Location			
Sattimore, semit. Pages 1 is Separiment of Hea moortant: it hem my injury or othe asse.		P☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		State	cemetery,	cremetory or	other ple	ce)						
E sette	+	21. Signature of Funeral Service Licer		101	blate			ss of Facilit		/31/99 0		Mary	Tand	
Danit. Depart Import any inj ansa		1 Donas de	2.1	e de						rals, P.		aryla	and 21921	
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that one cause on	caused the deach line.	leath. Do not	enter the mo	ode of dyli	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between	
Physician												1	Onset and Death	
/Medical		Immediate Cause (Final disease or condition	. mete	Silvie	CCIAC		C1	as Cal	Day of	20		1	2 uns	
Examiner		resulting in death)	a. 111600		o (or as a co			t	4/4/	DOLY		1	0 410	
	ě				. (0. 00 0 00		7.							
cate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions,	b	Due t	o (or as a coi	nsequence of	n):							
D sen		if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury												
ficate be experients the burian	edical	that initiated events resulting in death) Last	C	Due to	o (or as a cor	sequence of):						- 151.04	
ing ing	≥	resulting in death) cast	d											
that the death of detached for us	Physician/		u											
the dy	X	Part II. Other aignificant conditions of	ontributing to d	leath but not	resulting In th	ne underlying	cause giv	ren in Part I					o the causa of death?	
										101	as 20 No	3 Pro	bebly 4 Unknown	
necords,	b b									24a. Was i	no autonou	24h W	ere autopsy findings	
been si should	Completed									perfor	med?	av	vailable prior to empletion of cause	
has b	9											of	death?	
	S									1 U Y	es 2 No	11	☐ Yes 2☐ No	
ysiclen: The lis certificate hidirector, page		25. Was case referred to medical						26. Place	of Death	(Check only or	ne)			
Physician: This cartific	0	axeminer?	Hospital: 1	Inpatient 2	2 ☐ ER/Outp	atlent 3 [DOA Ott	ner: 4□ Nu	irsing Hor	me 5 Aesid	enca 6 🗆 Otl	her (Specia	fy)	
o Ph 19 Ph 19 Ph 19 Ph		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date	of Injury	28b. Tim		28c. Inju	y at	12	28d. Describe h	ow Injury occu	rred		
Attending or death.	atic	2 ☐ Accident investigation	1		, in the	M		Yes 2□	No					
OIVISION OF VITAI after death. Director: After this certificat d in by the funeral director, p.	Certification:	3 Suicide 6 Could not be determined	286. Place	e of Injury - A ling, etc. (Spi	t home, farm	, street, facto	ory, office		2	281. Location (S City or Tow	itreet and Num n, Stete)	ber or Rure	al Route Number,	
illed illed														
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	29a. Certifier (Check only one) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation.								d place, e th occurre	ace, end due to the cause(s) and manner as stated. accurred at the time, date and placa, and due to the cause(s)				
To the composition of the compos	29b. Signeture end title of certifier 29c. License number								29d. Date signed (Month, Dey, Year)					
		MX MX D44102							2	7/30/99				
1.6		20. Name and address of account		171-D	Itom CO. 1	P	.0	, ,,,,			1100	111		
10		30. Name and address of person who			,		5	en 1 1		M- 4	3 0100	1		
		William Renzulli, 31. Date filed (Month, Dey, Year)				urton	Road	, EIK	con,	Maryla	na 2192	T		
State Registra	5	JUL 3 0 1999	Bene	Registrar's Si	G.	Soons	2							
ricgistia			1	7	/ /		-							

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State of Maryland / Department of Health and Mental Hygiene 9 9 9 5 6 9 6

			Decedent's Name (First, Middle, Las.				cate of	Death	2. Data of De	Reg. No.	3. Time of Death
п	Physicia	an							Month	Day Yes	Br
4	/Medic	:al		avely						22, 1999	2:30 pm
	Examin	er	4a Facility Name (If not institution, giva	· ·				4b. City, Town, or		h 4c. County of D	eath
			3839 Hamilton Str				lada d Vana	Hyattsvi			George's
	Funeral Director		5. Social Security Number 6. Se 187–30–0033 Usual Residence of Decedant	7. Ag	a (In yrs. last bi 104		Inder 1 Yaar oths Days	If Under 24 Hrs Hours Min.	8. Data of Bir (Month, De July 1	9. 1895 Pe	Birthplace (State or Foreign Country) ennsylvania
	pung *		10a. Steta 10b. County		10c. City, Tow	vn or Location	1				10d. toside City Limits
	Mary	0	Maryland Prince Ge	orge's	Hyatts	sville					1 8 Yas 2 □ No
	288 1000	Director	10e. Street and Number	0280 0	1170000	-	f. Zip Code			10g. Cilizen of What	Country?
	23e or		3839 Hamilton Str	eet			20781			U.S.A.	
21215-0020	n 72 hours after death with the Maryland *natural*, or Herna 23a or 28a-f ahow salcal Examinar must be notified at	by Funeral	11. Maritel Status 1 Never Merried 2 Married 3 W Widowed 4 Divorced	12. Was Decedent Armed Forcas? 1 Yes 2 1 If Yas, Giva Yaar or Dates:			Decedent of H specify Cuba as 2 No	dispanto Origin? (S an, Mexican, Puerl Specify:	pecify Yas or No o Rican, etc.)		merican Indian, Thita, etc. White
5-0	72 ho	g g	15. Decedent's Edu (Specify only highest grad	ication	16a	Decedent's	Usual Occup	Pation	kina	16b. Kind of Busine	ss/Industry
21	within and the state of the sta	Completed	Elemantary/Secondary (0-12)	College (1-4or 5	i+)			during most of word)	KING		
21	giene.	NO.	8		Но	usewif	e			Own Home	
Pu	年工会を	Be	17. Fathar's Nama (First, Middle, Last)					18. Mother's Ner	ne (First, Middle	, Maiden Surname)	
la	should be nd Mental nmarked umartic ev	0	John V. Ulrick					Rose A.	Krebs		
Maryland	& BEE		19e. tnformant's Name/Raiationship (7)	vpe, Print)	19t	o. Mailing Add	drass (Street	and Number or Ro	ıral Routa Numb	per, City or Town, State	a, Zip Code)
	D = 22	- 1	Charlotte Houston	- Daught	er 38	39 Ham	ilton	Street,	Hyattsv	ille, MD 2	0781
re	w - = 0		20a. Method of Disposition		20b. Place 0	of Disposition	(Nama of	cel	Data	20c. Location - City	or Town, State
E	Peges nent of int: If Its		1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Othar (Specify)						7/27/99	Littlesto	wn . PA
Baltimore,	it.		21. Signature of Funaral Sarvice Licens		pe. mey						wii, 111
B	Depa Impo		· Claudett	Ed 2	rock			ss of Facility Tuneral H Timore Av		A. yattsville	, MD 20781
			23a. Part1. Entar tha disaasa, or complishock, or haart failura. List only o	ications that caused	tha daath. Do	not antar the	moda of dyir	ng, such as cardied	or respiratory a	rrest,	Approximate Intarval Between
	Physician								- 11		Onset and Deeth
	/Medical		tmmediata Causa (Finel disease or condition	_ (ongo	eotiv	e H	east f	aclus	2	4 months
	Examiner		rasulting in death)		Due to (or a a						
	D #	nei									
	icate be executed physicien and s the burial-transit	edical Examiner	Sequentially list conditions,	0	Dua to (or as a	consequence	of):				
o	e exe	Ě	Sequentially list conditions, if any, leading to immadieta cause. Enter Undarlying Cause (Disaase or Injury								
68760,	ifficate be execut g physicien and as the burial-tran	Ca	that initiated evants rasulting in daath) Last	C	Dua to (or as e	consequance	of):				1
	- 0 6										
Box	death cer e attendir ed for use	2		d							
	deat of fo	흥	Part II. Other significant conditions cor	ntributing to death bu	at not resulting I	n tha undarly	ing causa ok	ven in Part t.	23b. Did	tobacco use contrib	ute to the cause of death?
P.0	requires that the death cent een signed by the attendin hould be detached for use	Physician/M							1 🗆	Ysa 2010 3	Probably 4 Unknown
Records,	sign p	d by							24a Was	an autopsy 24	b. Were autopsy tindings
0	v require been si should	Completed							perfe	omed?	evailable prior to completion of cause
Sec	e law has b	dr.									of death?
	The la	8							10	Yes 2 → No	1 ☐ Yas 2 ☐ No
Viital	ysician: The	Be	25. Was case rafarred to medical axaminar?	19-1			100	26. Placa of Dea	ath (Check only	one)	Spile
of	hy hy	2	Tas Zerivo		nt 2 ER/O		DOA	4LI Nursing F		dence 6 Other (S	Specify)
	Affect	ou	27. Mannar of Beath 1 Natural 5 Pending	28a. Dete of Injur (Month, Day		Tima of Injury	28c. Injur		28d. Describe	how injury occurred	
Sio	Attending r death. sctor: Afte by the fund	cati	2 Accident invastigation			М	10	Yas 2 □ No			
Division	the d	Certification:	3 Suicida 6 Could not be datermined	28a. Place of Inju- building, ato		arm, street, fa	ctory, office			(Street and Number of wn, Stata)	Rural Routa Number,
0	pital or ours after eral Dir filled in	Ö									
	Hose Pun Park Mary	edical			examination en					cause(s) and manner date and place, and	
	To the within: To the comple	M	29b. Signetura end title of gertifiar	0 0			29c. Licens	se number		29d. Data signed (Me	onth, Day, Year)
	0		1600	Asla	no N	W		308	98	July 23,	1 0 0 0
,	[-]	-	30. Name end address of person who co	moleted assess of d	anth (them one)	(Tuno Prim)	0	000	20	July 23,	1777
	(5)		Steven Osborne, M.				rchard	Drive	Silver (Spring, MD	20904
					r's Signature	L LUIII U	renard	DITAG,	OTTAGE !	phring, un	20704
	Stat	ie ar	31. Data filad (Month, Day, Year) JUL 2 6 1999	heren	~ B	1	a 1/2/				

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	R	eg. No.	25435
	Decedant's Name (First, Middle, Last)	2. Data of Dea Month		3. Time of Death
Physician /Medical	Patricia Ann Smith Sasscer		20, 1999	9:05 am
Examiner	4a Facility Nama (II not institution, giva street and number) 4b. City, Town, or Loc		4c. County of De	ath
	16508 Marlboro Pike Upper Mar	lboro	Prince	George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs.	8. Data of Birth (Month, Day		Sirthplace (State or Foreign Country)
Director		April 7,	1933 M	aryland
2	Usual Rasidence of Decedant			
aryla above	10a. State 10b. County 10c. City, Town or Location			10d. fnside City Limits
Series Mi	Maryland Prince George's Upper Marlboro			1 ☐ Yes 2 No
vith the Ma or 28a-f s be notified Director	10a. Street and Number 10f. Zip Code	1	0g. Citizen of What (Country?
23 E	16508 Marlboro Pike 20772		U.S.A.	
72 hours after death with the Maryland 72 hours after death with the Maryland natural, or items 23a or 28a-f show stell Examiner must be notified at stell by Funeral Director	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe. If Yas, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - An Black, Wi	nerican Indian, hita. etc.
or h	1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify:		Specify:	
natural', o	3 LAWidowed 4 □ Divorced Yaar or Datas:			White
ed within 72 ho ygiene. or than "nafurn ft, the trade	15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuaf Occupation (Give kind of work done during most of workin life. DO NOT use retired)	ng	16b. Kind of Busines	:s/Industry
d within giene. Tr than	Elemantary/Secondary (U-12) College (1-4or 5+)			
other the Co	5+ Licensed Registered Nu		Private 1	ractice
be filed of other event,	17. Fathar's Name (First, Middla, Last) 18. Mother's Nama		waiden Surname)	
d 2 should be th and Mental 7 is marked of traumatic every traumatic every To Be	Herbert Joseph Smith Dorothy			
2 2 2 2	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 19c. 10c. 20c. 20c. 20c. 20c. 20c. 20c. 20c. 2			
M Health Hem 27 other tr	Robert Beale Sasscer - Son 16508 Marlboro Pike, Up			
permit. Pages 1 an Department of Heal Important: If Nem 2 any Injury or other price.	20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	/23/99	20c. Location - City of	or Town, Stata
Parmen and:	4 Donation 5 Other (Specify) Trinity Episcopal Church Cemetery	123/33	Upper Mar	lboro, MD
mport in July In July	21. Signatura of Funaral Sarvice Licensee 22. Nama end Addrass of Facility Gasch's Funeral Home	D A		
89778	Claudette J. Dasch 4739 Baltimore Aven		tteville	MD 20781
	23a. Part 1. Entar tha disaasa, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or shock, or haart failura. List only ona causa on aach lina.	respiratory arr	est,	Approximate Interval Between
Physician	Shouk, or heart failure. List only one cause on each line.			Onset and Death
/Medical	Immediate Causa (Final disaasa or condition AULA CIARCIIACO IAI A			in/98
Examiner	disaasa or condition rasulting in death) a. Lung CARCI WO WA Due to (or as a consequence of):			1 10/12
je c	liver metro trecee			3/99
emouted in and rat-transit Examiner	Sequentially list conditions Due to (or as e consequence of):			
be smoov loten and burist-tra	Sequentially llst conditions, if any, leeding to immadiate gauss. Entar Undartying			
thcata be exaculty physician and as the burist-tra	Cause (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of):			
5 94 4	rasurary in Gooth) Cast			
attendin I for use clan/N	d			1
at the death cer d by the attendir stached for use Physician/A	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.	23b. Did to	becco use contribu	ite to the cause of death?
hat the do to by the deteched		12XY		Probably 4 Unknown
	COLD			
The law requires th cate has been signed, page 2 should be d	Smokius	24a. Wes a		Wera autopsy findings available prior to
law requi	Smokius	perfor	ned?	completion of cause of death?
The law ate has page 2			s advo	
F and O	26. Wee care relevant to medical	1 Y		1 ☐ Yes 2 ☐ No
Physician: The Intercept of the Co. page 170 Be Co.	25. Was case referred to medical examinar? 1			
Physics of the Control of the Contro	1 Linpatient 2 LER/Outpatient 3 LIDOA 4 Li Nursing Hon		once 6 Other (Sp ow injury occurred	secify)
ding i	1 Natural 5 Pending (Month, Day Year) tnjury Work?			
tal or Attending P or attendesh. Is Director: After led in by the funera Certification:	3 Suicida 6 Could not be	8f. Location (S	reet and Number or	Rural Routa Number,
or Athending Physician: The law requires the after death. Director: After this cartificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	4 Homicide datamined datamined building, atc. (Specify)	City or Town		
D EFSE	29a. Cartifiar Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, a	nd due to the a	busale) and manne	ac etalod
ne Hospi n 24 hos ne Funer pletoly III edical	(Check only one) Control one) Control one in the case of a xaminetion and/or investigation, in my opinion, death occurred and mannar stated.	d at the time, d	ate and place, and d	ue to the cause(s)
Mee Mee	200 License number	2	9d. Date signed (Mo	nth, Day, Year)
5 200	Alai G. Cleanpale MS D42049			
120			July 21	
42/	30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Alaiu - G. CHAMPALOUX MD. Upper M	on the	ro. MI	0.20772
		-0.000		
State	31. Data filed (Month Cay Y1999) 2. Registrar's Signatura			

early Reigns III

State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nama (First, Middla, Last)	Reg. No.	3. Time of Death						
Physician	Emily Evaline Sheets	Month Day July 27.	1999 9:00 A.M						
/Medical Examiner			County of Death						
Examine		owie Pr	ince Georges						
Funeral Director	5. Social Sacurity Number 214-52-3088 6. Sax 7. Aga (In yrs. last birthday) Yrs. 70 1 Usual Rasidance of Decedant	Min. B. Data of Birth (Month, Day, Year) July 27,	9. Birthplaca (Stata or Foraign Country) 1929 Set Virginia						
M 18	10a. Stata 10b. County 10c. City, Town or Location		10d. Insida City Limits						
notified at irector	Md. Prince Georges Bowie		1 Yas 2 No						
r tems 23a or 28a-f show niner must be notified at Funeral Director	10e. Street and Number 12654 Heming Lane 10f. Zip Coda 20715	10g. Chiz	en of What Country?						
ir, or its	11. Marital Status 1 □ Navar Married 2 □ Married 1 □ Navar Married 2 □ Married 1 □ Navar Married 4 □ Divorced 1 □ Yas 2 □ No If Yas, Giva Yaar or Datas:		4. Race - Amaricen Indian, Black, Whita, atc. Specify: White						
ygiene. Net than "natural", It, the Medical Exa	15. Decedant's Education 16a. Decedant's Usual Occupation (Specify only highast grada completed) (Giva kind of work done during most	of working 16b. Kin	nd of Businass/Industry						
than the	Elamentary/Secondary (0-12) Coilega (1-4or 5+)		4-21						
T 2 2 0	8 Cashier 17. Father's Nama (First, Middla, Last) 18. Mother	r's Nama (First, Middla, Maidan S	Sumama)						
marked o	Rufus Linzie Trail	Sara Elizabet	h Hogoston						
e m	19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number	r or Rural Routa Number, City or	Town, Stata, Zip Coda)						
other tr	George H. Sheets - son 12654 Heming Lan 20a. Mathod of Disposition (Noma of	-	20715 cation - City or Town, Stata						
	Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Camatary, cramatory or other place) Grandview Memory Ga	07-31-99	field, VA.						
Department of important: If any injury or pace.	21. Signature of Junaral Servica Licensaa 22. Nama and Addrass of Facility	Reall Funera	1 Home						
3200	Shannon W. Beall Mo0798 6512 N.W. Cra 23a. Pert1. Enter tha disease, or complications that caused the death. Do not enter tha mode of dying, such as of shock, or haart failura. List only one cause on applications.	in Hwy., Bow	ie, Md. 20715						
ysician	shock, or haart failura. List only one causa on aach lina.	cerdiac or raspiratory arrest,	Approximata Intervel Between Onsat and Daath						
edical	Immediata Causa (Final disaasa or condition PANCREA 750 CAMCER		702176						
niner	disease or condition resulting in death) Due to (or as a consequence of):		1 1000 101						
iner									
physician end the bunal-trensit dical Examiner	Sequentially list conditions, if any, leading to immediate								
	Sequentially list conditions, if any, laading to immadiate ceusa. Enter Underlying Causa (Disaase or injury that initiated avants								
2 6 6	rasulting in daath) Last Dua to (or as a consequence of):								
be deteched for use by Physician/M	d		1						
sici	Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.	23b. Did tobacco i	uee contribute to the cause of death?						
Phy		1 ☐ Yee 2 [3 Probably 4 Unknown						
		24a. Was an autop:	sy 24b. Wara autopsy findings						
		parlormed?	available prior to completion of cause of death?						
s certificate has director, page 2 fo Be Comp		1 ☐ Yas 2 ☐	THE 1 Yas 2 No						
ertificat ector, p Be C	25. Was cesa refarrad to medicel 26. Placa	of Daath (Check only ona)	10110 3910						
	axaminar? Hospitel:	rsing Homa 5 Hasidance 6	□Other (Specify)						
er thi	27. Menner of Deeth 28a. Data of Injury 28b. Tima of 28c. Injury at	28d. Dascribe how injury							
he fur	2 Accidant invastigation M 1 Yes 2 N	No							
al Diractor: After tiled in by the funeral Certification:									
to the Funeral Diractor: After this completely filled in by the funeral di Medical Certification: To	29a. Cartifiar (Check only one) 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, data and 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death and mennar steted.								
To the Funeral completely filled	29b. Signature and title continue () (20) Au (20) 20352 27/27/89								
10)	30. Nama and address of person who completed cause of death (Item 23e) (Typa, Print)	toold di	JON MA						
	TIME TIME TO THE TOTAL TO THE TOTAL	In Val							
State	31. Data filed (Month, Day, Year) 33. Registrar's Signature								



State of Maryland / Department of Health and Mental Hygiene 99 25437

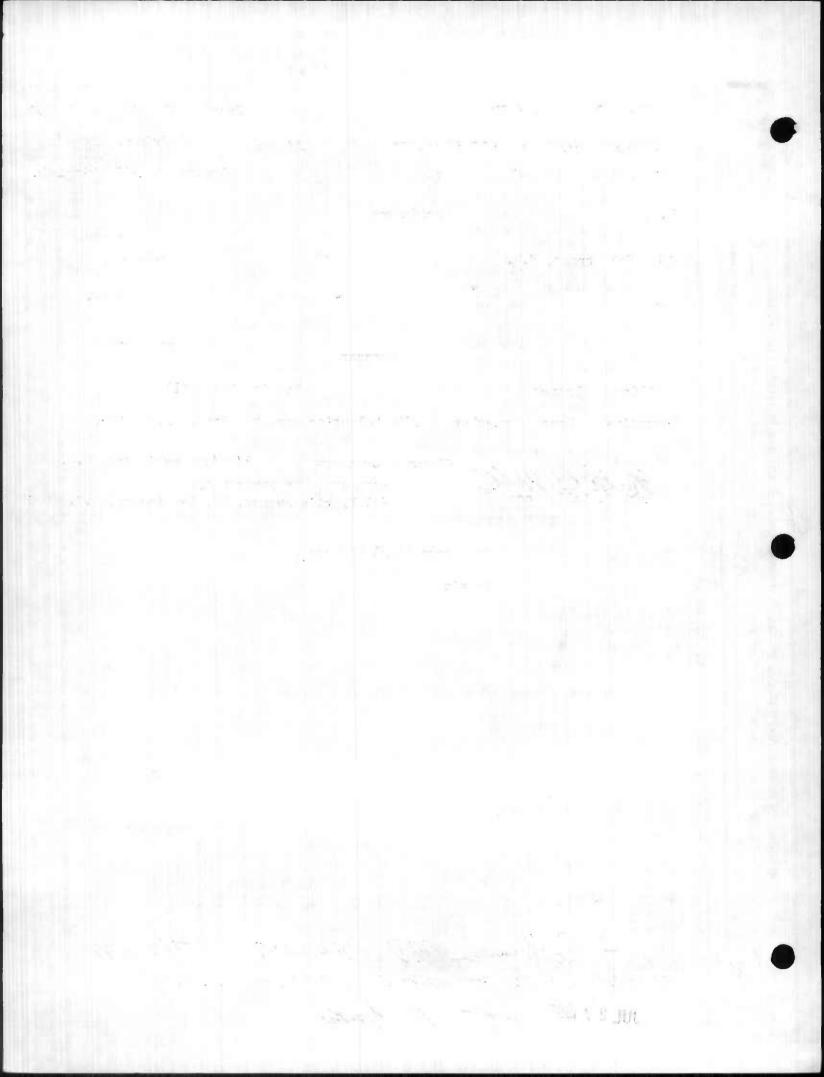
			Cer	tificate of	Death		Reg. No.	, ,,	
Obs. of state	1. Decedent's Name (First, Middle, L.	ast)				2. Date of Month	Death	Year	3. Time of Death
Physician /Medical	Evelyn Sherr	man				Jul-	y 21,	1999	5:15 AM
Examiner	4a Facility Name (If not institution, gi	ve street and number)		4	4b. City, Tow	n, or Location of De	ath 4c. Cour	nty of Death	
	Hebrew Home o	f Greater Wa	shingt	ton	Rock	ville	Mor	ntgom	ery
Funeral		Sex 7. Age (In yrs.	last birthday)	If Under 1 Year		4 Hrs. 8. Date of	Dirella	O Dieb.	iace (State or Foraign
rector	150-36-9343	1□M 20(F 89	Yrs.	Months Days	Hours	Min. Feb.	3,1910	Nei	w Jersey
	Usual Residence of Decedent				1				
eted by Funeral Director	10a. State 10b. County	10c. Ci	ty, Town or Loc	cation				1	Od. Inside City Limits
Ş	VA Fairf	ax Re	ston						1 Yes 2 □ No
Directo	10e. Street and Number	1 110		10f. Zip Code			10g. Citizen o	f What Coun	itry?
0	11540 Links D	r.		2019	90		Unite	ed Sta	ates
Funeral	11. Marital Status	12. Was Decedent Ever in L	J,S. 13. V	Vss Decedent of H	lispanic Origi	in? (Specify Yes or		ace - Americ	
בֿ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No	H	Yes, specify Cuba	an, Mexican,	Puerto Rican, etc.)	В	lack, White,	atc.
þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Datas:	1	☐ Yes 2☐XNo	Specify:		Spec	wh:	ite
8	15. Decedent's E	ducation	16a. Deced	ent's Usual Occup	pation		16b. Kind of	Business/Inc	
Completed	(Specify only highest gr	ade completed)	(Give I	kind of work done of NOT use retired	during most	of working			
E	Elementary/Secondary (0-12)	College (1-4or 5+)		Homema	aker		Owr	1 Home	e
O	17. Father's Name (First, Middle, Las	0	1			's Name (First, Mide	1		
9 Be	Morris Peski:	n			Ann	ie Levi	tt		
9	19a. Informant's Name/Ratationship		10h Mailin	n Addrage /Street		or Rural Route Nu		en State Zin	Codel
	Ruth Ellen Dah					Reston		2019	
	20a. Mathod of Disposition		Place of Dispos			Data	20c. Location		
	1 □ Burial 2 □ Cremation 3 [Removal from State	cemetery, crem	atory or other place			1 1 1 1 1 1		
	4 Donation 5 Other (Spec	by S	tar of	David	Cem.	7/23	N. La	uerd	ale, FL
	21. Signature of Fahoral Service Lice	ng66 // ` /	22.	Name and Addre	ss of Facility	Stein	n Hebre	w F111	neral
	V// (what	15.1	2.3	32 Carro	011 S				DC. 20012
	23a. Part1. Enter the disease, or con	plications that could the dea						,011,	Approximata
	shock, or heart failure. List only	one cause on each line.							Onset and Death
	Immediate Cause (Final	Arteriosu	Ponte	a heart	hand	langi			7 17
	disease or condition resulting in death)				-wa	- wy		/	MEMORI
9		Due to (or as a consequ	Jence OI):					
声		b.						-	
Exa	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	Jerice OI):					
lec	ceuse. Entar Underlying Cause (Disease or injury that initiated events	C	The Personal Property of	D.					
edical Examiner	resulting in death) Last	Due to (d	or as a consequ	ience of):					
3		d							
100									
by Physician	Part II. Other significant conditions		sulting in the un				id tobacco use	/	the cause of death?
£	Chrome obst.	rectivo m	Imon	un di	earl	1	□ Yes 2 11 No	3 □ Prol	bably 4 Unknown
		6		7					
Completed							as an autopsy erformed?	avi	ere autopsy tindings aliable prior to
g								of	mpletion of cause death?
E						11	Yes 2440	1[Yes 2□ No
Be C	25. Was casa referred to medical			13	26. Place	of Death (Check on			
ToB	axaminer? 1 ☐ Yes 2 ☐ No	Hospital:	ER/Outpetient	3□ DOA Oth	or /	sing Homa 5 R		ther (Specif	V)
	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur			oe how injury occ		,
tlo	1 Natural 5 Pending 2 Accident investigation		Injury		rk? Yes 2∐N				
Certification:	3 Suicide 6 Could not t	00 Dines of lains. At h	ome, farm. stre			28f. Locatio		mber or Rura	Il Route Number,
Te	4 Homicide	building, etc. (Speci	ty)				Town, State)		
0	29a. Certifier 1 Certifying P	veloins. To the heat of my tra-	nulados dest	accurred at the st-	no data and	place and due to t	ha equantal and	manner se	tated
edical		nysician: To the best of my kno miner: On the basis of examina							
Med		and manner stated.		29c. Licens	n number		29d. Date sig	ned (Manth	Dev Veerl
	29b. Signature and title of certifier	MD				0	2 Jale sig	/ /ca	Lay, rodi)
0	1 miles con	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		DZ	3958		1/6	0/1/	
	30. Name and address of person who						-	1	
1	Dr. Bert I Fe	eldman, MD.	6105 N	lontrose	e RD.	Rockvi	lle, MI). 208	852
State	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature						
istrar	JUL 2 7 1999	Serva	A	lon de					
		A CONTRACTOR OF THE CONTRACTOR	· -	THE RESERVE AND A PROPERTY AND A PRO					

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State of Maryland / Department of Health and Mental Hygiene

sician		Decedent's Name (First, Middle, I	Last)	***				2. Date of De	eath Dey	Year	3. Time of Death
edical	_	FRANCES	E. SMITH					July		1999	8:50A
miner		Facility Name (If not institution, g	rive street and number,)			4b. City, Town, or			of Death	
		SOUTHERN MARY	LAND HOSPI	TAL (CENTER		Clintor	1		ce Geo	rge's
ral	5.	Social Security Number 6.	Sex 7. A		A	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	th ay, Year)	Country	e (State or Fore
r	-	578 28 7568	TE W ZEET	- 8	2 Yrs.			Februa	ry 23 1	917 V	irginia
	-	Da. State 10b. County		10c. City	y, Town or Locat	tion				10d	inside City Lim
to		D.C.		Wa	shingto	n					1 1 Yes 2 □
Funeral Director	10	De. Street end Number				10f. Zip Code			10g. Citizen of V	Vhet Country	7
a D		1908 6th Street	. N.W.			2000	1		U.S.	Α.	
ner	11	. Marital Status	12. Was Decedent Armed Forces		S. 13. Wa	s Decedent of I	Hispanic Origin? (S an, Mexican, Pue	Specify Yes or No	- 14. Rac	e - American	
		1 Never Married 2 Married 3 Widowed 4 Divorced				Yes 2 No		,		Black	
Completed by		15. Decedent's	Education		16a. Deceden	t's Usual Occu	pation		16b. Kind of Bu	ısin ess/i ndus	stry
ple	-	(Specify only highest (Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO	NOT use retire	during most of wo	orking	Dry C1	aanar	
Con		12th			Pre	esser			- 6		
Be	17	'. Father's Name (First, Middle, La	st)						, Maiden Sumam	10)	
10	_	William Latr					Fannie		Hill		
		9a. Informent's Name/Relationship					and Number or A				ode)
	-	Edwardine Ros a. Method of Disposition	ss, Daugth		lace of Dispositi		ie Ave.,	Date Date	20c. Location -		State
pnce. To Be C	-	1 Sp Burial 2 ☐ Cremation 3		CI	emetery, cremat	tory or other pla					
-	2	4 Donation 5 Other (Special Service L	and III	g GL	enwood (Jemeter		1/29/99	Washing	geon,	0.0.
Succession	1	Ruth C. Hall	cco347		H.	ALL BRO	THERS FU				
	1,	3a. Part1. Enter the disease, or co shock, or heert failure. List on		d the death	62	21 Flor	ida Avent	ue, NW,	Washingt	on, D	.C. 200
Examiner	Sif	equentially list conditions, any, leading to immediate	Sep	Due to (or	r as a conseque	nce of):					
		ause. Enter Underlying									
dical	C th	equentially list conditions, any, leading to immediate ause. Enter Underlying euse (Disease or Injury at Initiated events ssulting in deeth) Lest	c	Due to (or	as a conseque	nce of):					
\/Medicai	C th	ause. Enter Underlying euse (Disease or Injury lat Infliated events sulting in deeth) Lest	d	Due to (or	r as a consequer	nce of):					
-	C th	isulting in deeth) Lest						000 814			
-	C th	ause. Enter Underlying euse (Disease or Injury at Initiated events sulting in deeth) Lest art II. Other significant conditions					ven in Part I.		tobacco use co		
-	C th	isulting in deeth) Lest					ven in Part I.		tobacco use col Yes 2□ No		
by Physician/M	Pr	isulting in deeth) Lest					ven in Part I.	1 🗆	Yes 2 No	3 Probal	bly 🌠 Unki
by Physician/M	Pr	isulting in deeth) Lest					ven in Part I.	1 🗆	Yes 2□ No	3 Probat	eutopsy findinable prior to
by Physician/M	Pr	isulting in deeth) Lest					ven in Part I.	1 🗆 24a. Was peri	Yes 2 No	3 Probat	eutopsy findinable prior to
e Completed by Physician/M	Pa Pa	art II. Other significant conditions 5. Was case referred to medical				erlying cause gi	26. Place of De	1 🗆 24a. Was peri	Yes 2□ No sen autopsy ormed?	3 Probat	eutopsy findin able prior to eletion of cause ath?
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To Be Completed by Physician/M	Per Per Per Per Per Per Per Per Per Per	art II. Other significant conditions 5. Was case referred to medical examiner? 1	Hospital: A Inpati	out not resu	ulting In the unde	arlying cause gi	26. Place of De her: 4□ Nursing ry et fr?	24a. Was peri	Yes 2□No s en autopsy ormed? Yes 2□No one)	3 Probet 24b. Were availate composed to de the composed to th	eutopsy findin able prior to eletion of cause ath?
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edical Certification: To Be Compieted by Physician/M	25 27 29 29	art II. Other significant conditions 5. Was case referred to medical examiner? 1	Hospital: 28e. Dete of injuicion 28e. Placa of individing, e	pout not result of my know of examinatiated.	ER/Outpatient 28b. Time of Injury ome, ferm, street	3 DOA Of 28c. Injuned of the titligation, in my	26. Place of Deher: 4 Nursing ry et rk? IYes 2 No me, date end plec	24a. Was perfi	Yes 2 No sen autopsyormed? Yes 2 No one) idenca 6 Oth how injury occur (Street and Numb wn, State) ceuse(s) and ma dete and place,	3 Probat 24b. Were availate composite of de to the composite of the compo	eutopsy findinable prior to oletion of cause ath? resulting the second of cause ath? resulting the second of cause ath?



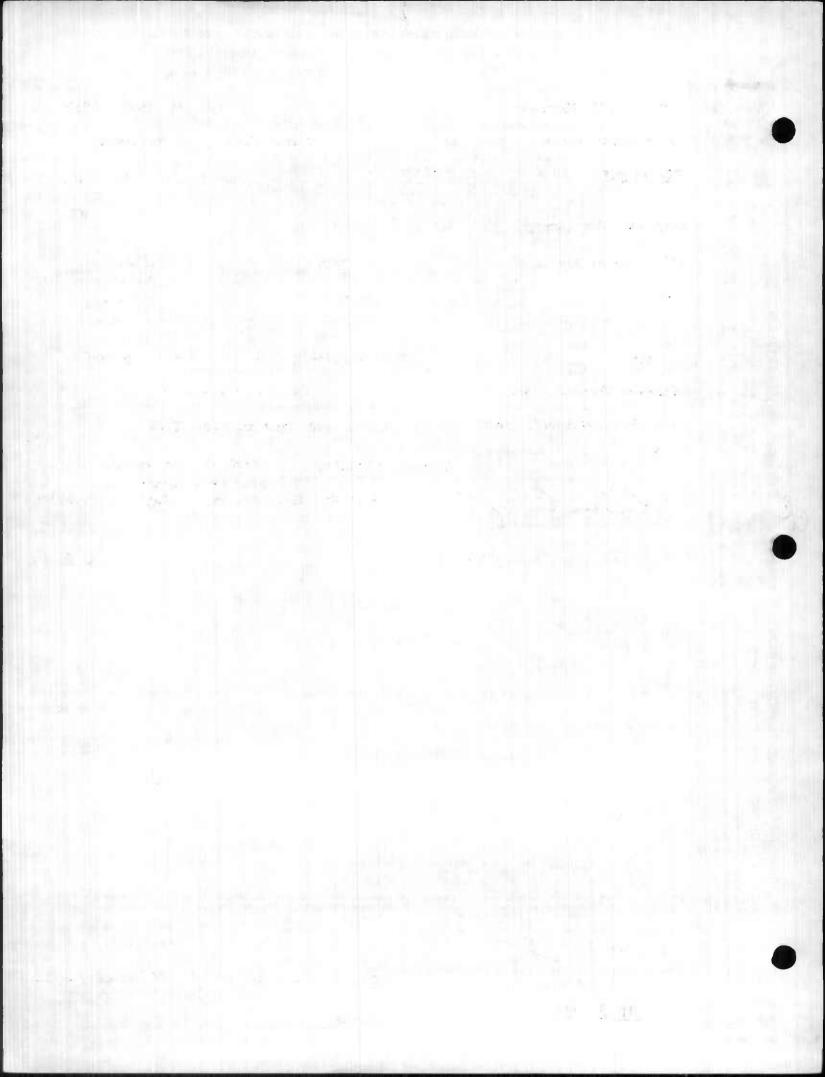
Medical aminer eral	4a Facility Name		W.	J 1	arks			JULY	26	99	10:04	
al		(If not institution, give	street end number				4b. City, Town, or Lo	ocation of Deatl	4c. County	of Death		
	WASHING 5. Social Security	GTON ADVEN		ITAL ga (in yrs. last		ar 1 Yaar		RK 8. Date of Bir (Month, De	MONTO		Y COUNTY aca (Steta or Foreign by)	
pleted by Funeral Director	354-20-	9/40	MM 2□F	72	Yrs. Month	s Days	Hours Min.	MARCH 8		KENTU		
	10a. Stata	10b. County		10c. City, To	own or Location					10	Dd. Inside City Limits ÑXYes 2□No	
Funeral Director	MD	1	GEORGES	ADEL		n node			40- China -411	That Carret		
ă	10e. Street and N		11 = =			Cip Code			10g. Citizen of V			
eral	1820 ME	TZEROTT RD		Ever in U.S.		0783 redent of h	Ilspanic Origin? (Sp	ecify Yes or No	UNITED 14. Reca	STATE a - America		
	1 Never Ma	rried 2 Married 4 □ Divorced	12. Was Decedent Armed Forcas' 1 ☑ Yes 2 ☐ If Yes, Give Yaar or Datas:	? No		2 No	Hispanic Origin? (Sp an, Mexican, Puarto Specify:	Rican, etc.)	Specify	k, White, e BLA		
To Be Completed	/Sn	15. Decedent's Ed	ucation	10	Sa. Decedent's Us	ual Occup	pation	ina	16b. Kind of Bu	siness/Ind	ustry	
	Elementery/Se		College (1-4or	5+)			during most of work d)	9				
-	17 Father's Nam.	e (First, Middle, Last)	4		BUSINE	SS MA	18. Mother's Nam	e (First Middle	PRIV.			
	HARVEY S						MATTIE			-,		
-	19a. Informant's	Name/Relationship (Type, Print)	1	9b. Malling Addre	ss (Street	end Number or Rur			Stete, Zip	Code)	
	YVONNE	A. STARKS	/ WIFE		1820 M	ETZER	OTT RD #5	5 ADELI	PHI.MD 2	0783		
		isposition 2 Cremation 3 C 5 Other (Specify		ceme	of Disposition (A stery, cremetory o	leme of r other pie		Date	20c. Location -	City or Tov		
1		Furnishal Service Licen					ER S. POP					
	> (1)	Ver 1 to	ne h		1131	5 LOC	KWOOD DRI	VE. SII	VER SPR	TNC M	m 20904	
Physician/Medical Examiner	Sequentially list of any, leading to cause. Enter Un Cause (Disease that initiated ever rasulting in death	conditions, immediate derlying or Injury	b. Co.	Due to (or as	a consequence of a cons	the	art F	ailur	e			,
2	Part II Other eigr	ificant conditions o	ontribution to death I	out not reculting	n in the underlying	cause of	ven in Part I	23h Did	tobacco usa cor	ntribute to	the cause of death?	
1	rait ii. Other sigi	mean conditions of	Jithouting to death i	out flot resulting	g in the underlying	y cause gr	voii iii Patti.		Yss 2□ No	3 Prob		
a paraduna									an autopsy ormed?	ava	ore autopsy findings allable prior to impletion of cause death?	
								10	Yes 20 No		Yas 2□ No	
	25. Was case ref	erred to medical					26. Place of Deel	th (Check only	one)			
9	1 ☐ Yes 2 27. Manner of De 1 ☐ Natural	5 Pending	Hospital: 1 Inpati		Outpatient 3 Do. Time of Injury	28c. Inju Wo			denca 8 Oth		1)	
Cer till Cation.	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Placa of In	jury - At home tc. (Specify)	, farm, street, fect		1.00 2 110		(Street and Numb wn, Stete)	per or Rura	l Route Number,	
- Alicai	29a. Certifier (Check only one)		yalclan: To the best liner: On the basis of and mannar s	of examination								
Me	29b. Signature ar	nd title of certifier	0		240	9c. Licens	se number		29d. Dete signe	d (Month, I	Dey, Year)	
	- ×	ok-W.	fugela	XIII	MA	My	Hc 000	20432	26	201	4 44	
h	30. Name and ad	dress of person who	completed bailse of	death (Item 23	s) (Type, Print)							

					State o	i Maryia		artment of tificate of		d Mental H	ygiene Reg. Ne		9 2	5440
В	Discosite.		1. Decedant's Nama (Fil	rst, Middla, L	ast)					2. Data of D Month			Yaar	3. Tima of Death
J	Physic /Medi		Minervia	a May '	Tisdale					July	21.1		Taar	3;11a.m.
п	Exami		4a. Facility Nama (If not	institution, gi	va street end nu	m <i>ber)</i>			4b. City, Town,	or Location of Des	100		of Death	
7/			Holy Cro	ss Hos	spital				Silver	Spring		Mont	tgome	rv
П	Funeral	Г	5. Social Sacurity Number		Sax	7. Age (In yrs	. last birthday)	Il Under 1 Yea	II Under 24	Hrs. 8. Date of B	irth			ace (Stata or Foreign
8	Director		224-84-157	0	1□M 2∏F	8!	5 Yrs.	Months Days	nours n	June 2:	2.19	14	Virg	
	D.		Usuel Rasidanca of Dec								- J	n	var g	
	nylar how		10a. State 10b	. County		10c. C	ity, Town or Lo	cation					10	d. Inside City Limits
	Ma Miller	cto	Md. M	ontgon	nery	Si	lver Sp	ring						1 □ Yes 2 No
	th th	Director	10e. Street and Number					10f. Zip Coda			10g. Ci	tizan of V	What Count	ry?
	th wi	<u>8</u>	1505 Bail	eys La	ne			20906			U.	S.	A.	
	dea	Funeral	11. Marital Status			adant Evar in	U,S. 13. \		Hispanic Origin'	(Spacify Yes or N		14. Rac	a - America	
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(Check only one) 2d Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) 27d. Place of the cause(s) and menner stated.		Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Pert It. Other significant condition ANCMIA RENAL 25. Was case referred to medical exeminer? 1 Yes 26 No 27. Menner of Death 1 Neturet 5 Pending	b. Contact of the contributing to deat Contributing to deat Contributing to deat Contributing to deat Contributing to deat	Due to (or Due to (or Due to (or	res e consequence es a	uence of): UTGNY uenca of): dentying cause gir all DOA Other	DIS SA	23b. Did to 1 Ve 24a. Wes el perform 1 Ye Death (Check only on	n eutopsy ned?	3 Prob	re sutopsy finding illable prior to mpletion of cause leath?
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Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Nama (First, Middle, Last) Month July 18 1999 Whitaker 12 Noon 4b. City. Town, or Location of Deeth 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Future Care/Pineview Clinton Prince George's If Under 1 Year If Under 24 Hrs. Birthpleca (Stete or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1₩ 2□F Months Deys Hours Min Yrs July 23,1909 Georgia 89 Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 9106 Pineview Lane 20735 USA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 □ Navar Married 2 □ Married 1 ☐ Yes 2 No Specify: black Specify: 3 ⊠ Widowed 4 □ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Plumber Private 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Will Whitaker Blanche (unknown) 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mary H. Murrell / stepdaughter 517 68th St. Capital Heights, Maryland 20743 20b. Piece of Disposition (Nema of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 1 Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7-20 Alexandria, Virginia must Funeral Service Licenses 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746 en). Entar the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death ACUTE MYOCARDIAL INFARCTION About 5 min. more than Due to (or es e consequence of) CORONARY ATHEROSCLEROSIS 1 year Sequentielly list conditions, if any, leading to immediate cause. Enter Undarfying Cause (Diseese or Injury that Initiated events rasulting In deeth) Lest Due to (or as a consequence of) more than HYPERTENISVE HEART DISEASE l year Due to (or es e consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIABETES 24b. Were eutopsy findings evaileble prior to 24e. Wes en eutopsy HYPERTENSION completion of cause of deeth? 1 Yes ZE No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical axeminer? 28. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 8 □Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 1 Xcertifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 7-22-99 D50653

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

the Maryland r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Introprentite them 27 is marked other than "natural", or Hems 28a or 21 any injury or other traumatic event, the Medical Examples 200.000.

Baltimore, Maryland 21215-0020

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Funeral

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20e. Method of Disposition

Immediata Ceusa (Finel diseese or condition resulting in deeth)

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27. Menner of Deeth

1X Natural

2 Accident

3 ☐ Suicide

29a. Certifie

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11. Marital Stetus

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Certification:

Records, P.O. Box 68760, the death certificete be Division of Vital Physicien: funeral After or Attending r death. after death Director: the filled in by Hospital 24 hours pletely

Medical within 2 State

Registrar

DEALE CHURCHTON ROIAD 32 Registrer's Signeture

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

GYAN CHAND

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Day Month Year **Physician** Dale Maurice Wilson July 31, 1999 1945 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 245 C East High Street Elkton If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 11XM 2□ F Vrs Director 218-80-0582 38 July 2, 1961 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 Yas 2 No Directo Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? natural, or items 23s or must be 245 C 21921 East High Street United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Biack, White, etc. 11. Maritel Stetus 1 XYes 2 No 1979-If Yes, Give Yeer or Dates: 1981 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within than Elementary/Secondery (0-12) College (1-4or 5+) Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 98 2 should be f and Mental h is marked William Bessick Helen E. Wilson permit. Pages 1 and 2 should to Department of Health and Ment Important: If them 27 is marked 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen E. Wilson/ Mother 108 Milburn Street, Elkton, Maryland 21921 20b. Place of Disposition (Neme of 20a Method of Disposition 20c. Location - City or Town, Steta Dete cemetery, crematory or other place) 1 Buriat 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 8/6/99 Providence Cemetery Elkton, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Hicks Home for Funerals, P.A. Juhr 103 West Stockton Street, Elkton, Maryland 21921 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Intervat Between Onset and Deeth **Physician** /Medical Atheroscheritic Ceronary Vascular Disease Immediate Ceuse (Finet years disease or condition resulting in death) Examiner Dependent Diebetes Malitus years attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 á 1 ☐ Yaa ZZ No 3 Probably 4 Unknown signed t Alcoholism Records, þ 24a. Wes en autopsy performed? 24b. Were eutopsy findings evailable prior to Completed peen completion of cause of death? has page 2 : 1 ☐ Yes 2 No certificate 1 ☐ Yas 2 ☐ No Division of Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifical npletely filled in by the funeral director; Be 25. Was case referred to medicat 28. Place of Death (Check only one) Hospitai: 1 Inpatient 2 ER/Outpatient 3 DOA 1 No 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (Watural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) end manner steted. within 2 To the complet 29b. Signeture and title of certile 29d. Date signed (Month, Day, Year) 29c. License number Ju Mas D 15314 August 1, 1999 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Union Hospital, Elkton, Maryland 21921 H. Farkas, M.D

State Registrar

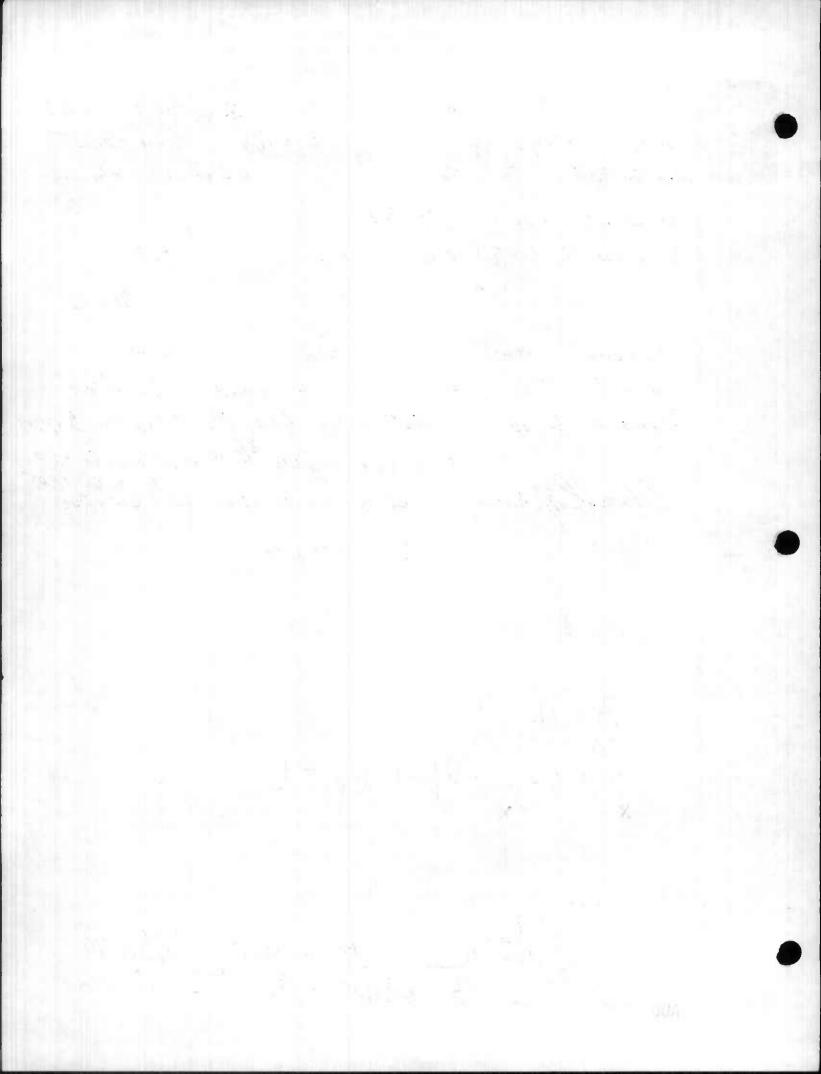
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32. Registrer's Signeture G. Spark

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mar		ertificate of			Reg. No.	V 9	. 0 11 10
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П	Funerai		Social Security Number 6. Se	7. Age (In yrs. lest birthda	Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthple Countr	ace (Steta or Foraign
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State of Maryland / Department of Health and Mental Hygiene

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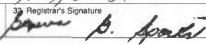
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	Funeral Director	5. Social Security Number 6. Sex 1 M M 2				#in. 8. Dete of Bill (Month, Di July 2	1936	Country)	
	and w	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, T	own or Location		_		10d. Inside City Limits	
	Mary 1 sh	Maryland Prince George	's Blade	ensburg				1 No Yes 2 No	
	vith the Ma or 28a-f s or notified Director	10a. Street and Number		10g. Citizen of W	/hat Country?				
	th will	5302 Taylor Street		U.S.A.					
020	72 hours after death with the Maryland natural*, or thems 23s or 28s-f show diest Examiner must be notified at seed by Funeral Director	1 Never Merried 2 Merried 1 Never Merried 2 Merried 1 Never Me	Decedent Ever in U,S. Id Forces? Yes 2 No S, Give or Detes:			7 (Specify Yes or No uerto Rican, etc.)		k, White, etc.	
Maryland 21215-0020	led within 72 hours lyglene. her than "natural", ft, the Wedies E.	15. Decedent's Education (Specify only highest grade comple Elementery/Secondary (0-12) Colle	ted) ge (1-4or 5+)	(Give kind of work life. DO NOT use	Occupation done during most of retired)	working	16b. Kind of Business/Industry		
7	other tr vent, the	17 Esthada Nama (First Middle 1 and)	1	Surveying	40 14 24 24	Name (First Affeld)			
and	A SES	17. Father's Neme (First, Middle, Last) Charles Herschell							
ary.	12 should be n and Mente is marked or reumatic ev	19a. Informent's Neme/Relationship (Type, Print))	19b. Meiling Address (2 Date of Death 2 Date of Death 3 Time of Death 3 Time of Death 3 Time of Death 3 Time of Death 3 Time of Death 3 Time of Death 3 Time of Death 3 Time of Death 3 Time of Death 3 Time of Death 3 Time of Death 4 County of Death 4 County of Death 4 County of Death 4 County of Death 4 County of Death 4 County of Death 4 County of Death 4 County				
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ore	of Herr	20a. Method of Disposition	20b. Plece	e of Disposition (Nemerlery, cremetory or off	e of ner plece)	Date	20c. Location -	City or Town, Stete	
Ë	ment ment: h	4 Donetion 5 Other (Specify)	Metr			07/22/99	Alexandr	cia, Virginia	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important! If Nem 27 is marke any Injury or other traumatic once.	21. Signeture of Funeral Service Licansee	1. Dasc	Gasch'	s Funeral	Home, P.A	\. vattavill	A MD 20791	
	Physician // Medical Examiner properties Cal Examiner Immediate Cause (Final disease or condition resulting in death)	erminal Caro Due to (or as	diac Arrhy saconsequence of): te Vascula:	thmia					
	v requires that the death certificate be assectled been signed by the attending physician and should be detached for use as the buriat-transit leted by Physician/Medical Examir	Cause, Enter underlying Cause (Disease or injury that initiated events resulting in death) Last d	20b. Place of Disposition (Neme of cemetery, cremetory or other place) Metropolitan Crematory 07/22/99 Alexandria 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville List only one cause on each line. Terminal Cardiac Arrhythmia Due to (or as a consequence of): c. Due to (or es a consequence of): d. Date 20c. Location - City Alexandria 20c. Location - City Alexandria 20c. Location - City Alexandria 20c. Location - City Alexandria 20c. Location - City Alexandria 20c. Location - City Alexandria 21c. Location - City Alexandria 22c. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville a. Terminal Cardiac Arrhythmia Due to (or as a consequence of): C. Due to (or as a consequence of): d. Due to (or es a consequence of): d. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I. 1 Yase 2 No 3 Contribution						
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ō	Physic relding relding	ILI Tes ZIA NO			4 Livuisiii				
Division	Attending or death. ector: After by the tune iffication	Neturel 5 Pending Investigation	Month, Day Year)			200. Describe now injury occurred			
DIV	Cert Cert	determined 288. F	Nece of Injury - At home uilding, etc. (Specify)	, farm, street, fectory,	office			er or Rural Route Number,	
	n 24 houns Funer pletely fill	(Check only 2 Medical Examiner: On the	ne basis of examinetion	dge, deeth occurred at and/or investigetion, i	t the time, date and pl in my opinion, deeth o	ace, and due to the courred et the time.	cause(s) and mai date end place, a	nner as stated. and due to the cause(s)	
	Me Me	29b. Signature, and little bit centifier	The steled.	29c.	License number		29d. Date signed	I (Month, Day, Year)	
	~ · · · · ·	· / / HAM I	10/11/	D'	52222		July 23	. 1999	
1	5)	30. Nema and address of person who completed	ceuse of deeth (Item 23						
()/	Meera Kanhouwa, M.D.			, Cheverly	, Marylan	d 20785		
	State Registrar	31. Dete filed (Month, Day, Year)	2. Registrer's Signeture	A. dra	1/1				

DHMH 16 Ray 6/95

Charles Wi

ANDERSON SETT WRIGHT TUTY 2 1, 1999 3 The debugs of the properties of the properti				State of	Marylar				and Mental H	ygiene) (Reg. No.	2	5449
ANDERSON KETT WRIGHT COUNTY 21, 1999 3:38 pm. Firstly three of material streamform one sense and numbers of the County of the Co	Dhua	lalan	1. Decedent's Name (First, Middle	, Last)							Year	3. Time of Death
## Particular for principles of principles o			ANDERSON	KEI	ТТ		WRIGH	-	JULY	21, 19		3:38 pm
Social Security Number Sec								4b. City, To	wn, or Location of Dee	eth 4c. Count	y of Death	
The control of the co		_										
Elementary/Secondary (0-12) College (1-dor 5-)	Directo		579-52-7038	10 M 20 F					Min. (Month, L	Day, Year) -1940	SOUT	H CAROLIN
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Elementary/Secondary (0-12) College (1-dor 5-)	er de	une		12. Was Deced	ent Ever in U es?				gin? (Specify Yes or N , Puerto Rican, etc.)	lo- 14. He		
Elementary/Secondary (0-12) College (1-dor 5-)	rs af			If Yes, Give			1□ Yes 2 1	No Specify:		Specia	y: BL	ACK
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25. Wes case referred to medical examiner? 1	law nes b	aldu		1	2	1	151			767	0	f death?
28a. Date of Injury - At home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occu		S	End VI	rage?	rene	ald	ar 14	se	1[Yes 2 No	1	☐ Yes 2☐ No
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30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) RAMAN R. (ULI, MD), 3503 PERRY STREET, MT. Rainier. MD 20712	papit hour mera ly fille		29a. Certifier Certifying	Physician: To the b	est of my kno	wledge, deal	h occurred at th	e time, date an	d place, and due to th	e cause(s) and m	nannar as	stated.
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) RAMAN R. (ULI, MD), 3503 PERRY STREET, MT. Rainier. MD 20712	he Hi he Fu pleta		one) 2 Medical E	end manne	r stated.	ation and/or ir	ivestigation, in n	2. Date of Death Reg. No. 3. Tims of Death Month Day Year JULY 21, 1999 3: 38 pm 4b. City, Town, or Location of Death TAKOMA PARK MONTGOMERY COUNTY 2f. 1940 No. 2f.				
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) RAMAN R. (ULI, MD), 3503 PERRY STREET, MT. Rainier. MD 20712	Tot Tot	Σ	29b. Signature and title of certifier					. 0			-	, Day, Year)
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31. Date filed (Month, Day, Year)
JUL 2 6 1999



Registrar

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		State o	f Ma	ryland				lealth a		Mental Hy	giene 9	9 /	25450	
1. Decedent's Nam	e (First, Middle,	Last)								2. Data of De	ath	-	3. Tima of Death	
Josephin	P	Virginia	9	T.	ren					July 2	4. 1999	Year	10:30 AM	
4a Facility Nama (/					LCII			4b. City, To	wn, or L	ocation of Death		of Death		
317	7 Aragor	na Drive						Ft.	Wash	ington	Prin	ce Ge	eorge's	
5. Social Security N	(In yrs. les	In yrs. last birthday) If Under 1 Yea				24 Hrs.	8. Data of Birt	h		Birthplace (State or Foreign Country)				
578-05-9		1□ M 2□XF		82	Yrs.	Months	Days	Hours Min. (Month, Day, Oct. 27			7 1916	1916 Wash., D.C.		
Usual Rasidence of 10a. State	10b, County			10c City 1	Town or Lo	cation							10d. Inside City Limits	
Maryland		e George'	s	Too. Oxy.			Wash	ingto	n				1 Yas 2 No	
10e. Street and Nur	mber					10f. Zi	o Code				10g. Citizen of	What Cou	ntry?	
317 Ara	agona Di	rive					20	744		- 1	Unit	ed St	ates	
11. Marital Status		12. Was Deci	edent E	ver in U,S.	13. V	Vas Dece	dent of h	lispanic Or	igin? (Sp	pecify Yes or No Rican, etc.)		e - Ameri ck. Whita.	can Indian, atc.	
1 ☐ Never Marri 3 ☑ Widowed		Armed For 1 Yes If Yes, Giver or D	/8	0	1	Yes, specify Cuban, Mexican, Puerto ☐ Yes 2K No Specify:				, , , , , , , , , , , , , , , , , , , ,	Specif	n1 1		
(Spec	15. Decedent's	Education grade completed)		1	16a. Deced	kind of wo	ork done	during mos	at of worl	king	16b. Kind of B	usiness/In	dustry	
Elementary/Seco		College (1	-4or 54	-)	Me. DO NOT use retired) Accounting					Government				
17. Father's Name		est)				1100	June	1	er's Nam	a (First, Middle,			10	
	rnest Be									ise Cha				
19e. Informent's Ne Regina		ip (Type, Print) on-Niece-	in-			_				Wash.,		State, Zij 744	Code)	
		3 □Removat from ecity)	Stata	cem	20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park 7/					Data / 29/99				
21. Signature of Fu 23a. Part / Enter the shock or has	w.L.	Devai	aused t	the death.		4001	Ben	4	Rd.,	tewart N.E. W	ash., D		20019 Approximata Interval Between Onset and Death	
Immediata Causa (diseasa or conditio rasulting in death)	MET	AS	TAT						MAS	OF LI	VER	EMM S		
•		FRO	M	UN UN	KV0	W W	a p	RIM,	AR)	SITE	_	1	2 (101-111)	
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury			C	ue to (or a	s a conseq	uence of)			-		f ma		H part	
that initiated events resulting in death) I			D	ue to (or as	a consequ	uence of):								
		d												
Part II. Other signif	icant condition	s contributing to de	eth but	not resultin	ng in the ur	nderlying	cause gi	ven in Part i	1.	23b. Did 1	~		o the cause of death's	
							1	100			an autopsy med?	an Co	fare autopsy findings vailable prior to emplation of causa death?	
										101	es 20 No		Yes 2 No	

Physician 7Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mertial Hygiens. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Director

Funeral

Be Completed by

To

Physician

/Medical

Examiner

Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Atlanding Physician: The lew requires that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the extending physician and To the Funeral Director: After this certificata has been signed by the attending physician and completely filled in by the funaral director, page 2 should be deteched for use as tha burat-transit

Division of Vital Records, P.O. Box 68760,

Part II. Other significant condi 25. Was case refarred to medical axaminer?

Yas 2□ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 27. Manner of Death
1 Di Natural
2 Accident 28d. Describe how injury occurred 28a. Data of fnjury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending Investigation 1 Yes 2 No 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier



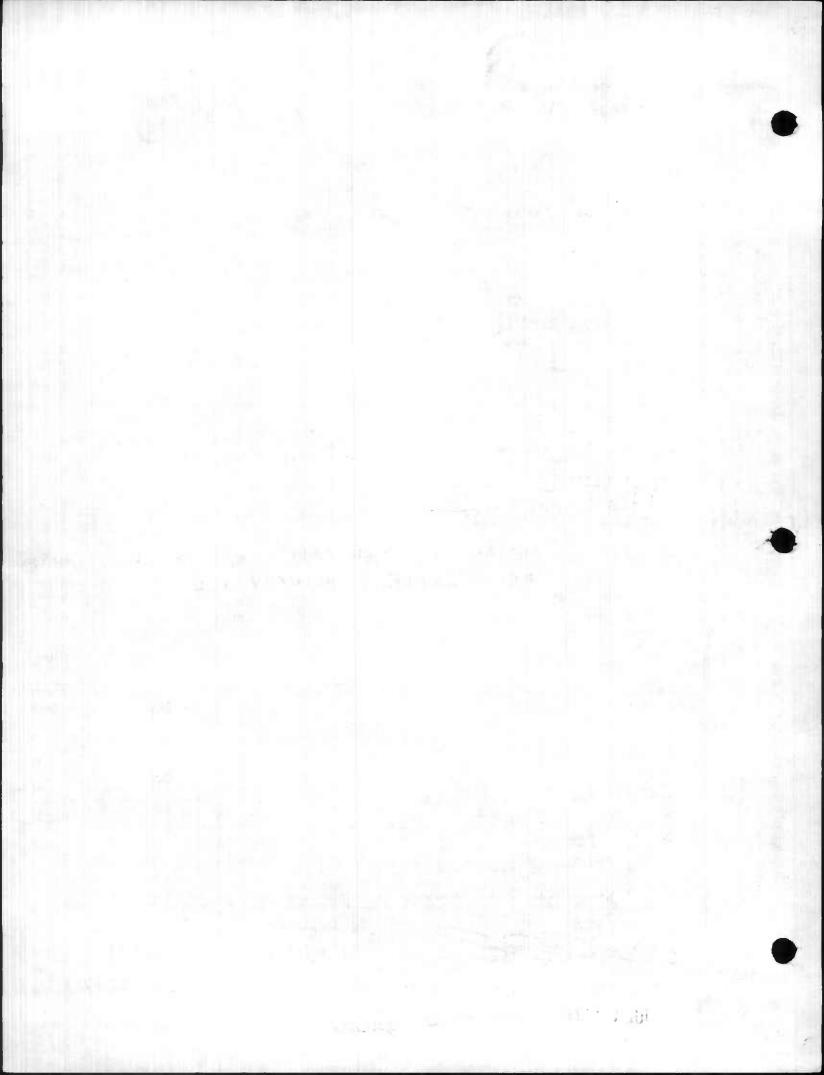
State Registrar

31. Data filed (Month, Day, Year)
JUL 2 7 1999

DAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1160 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ysician	_	#8 PER F.H. G774 : 1. Dacadant's Nama (First, M					rtificate c			2. Data of Daar Month	Day	Yaar	3. Tima of Death
redical aminer	al	LEE S. YAN 4a. Facility Nama (If not institu		a s <i>treet</i> a <i>nd n</i> um	n <i>ber</i>)			4b. City, Tov			4, 1999 4c. County)	2:30PM
IIIIIei		HCR MANOR CA						BETH			MONTO		Z
rai tor		5. Social Sacurity Number 534-86-3424		ax □M 2∏F	7. Aga (In yrs. 80	last birthday) Yrs.	If Undar 1 Ya Months Da		Min.	Data of Birth (Month, Day) CT 24	OCT. 14 Vaar) 1918	9. Birthp Coun TAIWA	laca (Stata or Foreig try) AN
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Director	Ctor	MARYLAND MONT	GOME	RY	POTO	OMAC							1 Yas 2 N
Dire	בַּ	10e. Street and Numbar	TONA	r cours			10f. Zip Cod	la			Og. Citizan of	What Coun	itry?
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		19a. Informant's Name/Ralation CHARLES C. YO					ng Address (Stre						Code)
		20a. Mathod of Disposition 1 Durial 2 Cramatic 4 Donation 5 Other			C	ematary, crei	osition (Nama of matory or other p EGO PION	placa)	M. 7/		20c. Location	-	wn, Stata OREGON
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ı	1	23a. Part1. Enter the disease shock, or heart failure. I Immediata Causa (Final disease or condition resulting in death)					ALEXA		VIRG cardiac or i	INIA 2: raspiratory arri	2314 ast,	24	Approximate Interval Between Onsat and Death
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aminer	48	Facility Name (III							4b. City, Town, or Upper Mai		th 4c. County Prince		rge's
ral		Social Security N 234-38-6		6. Sex 1 M 2		9e (In yrs. Ia: 74	yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month D May 15	rth Years 25	9. Birthpl Count West	ace (State or Foreig Virginia
	-	ual Residence of n. State	Decedent 10b. Count	ly		10c. City,	Town or Loc	ation				10	d. Inside City Limits
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by Funeral		Merital Status 1 Never Marri 3 Widowed		arried 1 [os Decedent ned Forces? Yes 2, 2, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,			Ves Decedent of P Yes, specify Cub	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	Specify	e - America k, White, e Whi	itc.
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by	-	t fl. Other signif	-4-1		o death b	ut not result	ng In the un	derlying cause gi	ven in Pert I.	1 C		3 Prob	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25453 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month **Physician** 4:00 AM AUSTIN TOBERT **DUGUST** 07 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE YA. MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dev. Year) 5. Social Security Number If Under 1 Year Birthpiace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 72 Yrs. 227-20-9133 Director MAKCH OI 27 VIRGINIA Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f show traumatic evant, ma Medical Examinar must be notified at Pos 2□No BRITIMERE Directo Marylow 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21217 KEISTERSTOWN U5A 2523 Funeral death 12. Was Decedent Ever in U.S. Armed Forcas? 1 Dryes 2 □ No 9-/5-50 17's, Give Year or Dates: 8' -2/5/ Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after or Depertment of Health end Mental hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, ma Mental Nevar Married 2 Married 1 Yas 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry SPATTOUS Elemantary/Secondary (0-12) College (1-4or 5+) STEEL WORKER 10 th grack 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) MALTHA STOKES N. JAMES 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHAM 7234 Orth Kano BRITHERE BrETHER 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition January 2 □ Cremation 3 □ Removal from State nson Forest Owings VE teran 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licentee 22. Name and Address of Facility CHATHER - HIRKS F any in 5240 RUSTERS frum LAD 23a. Part1. Enjer the disease, of complications that caused the death. Do not entar the mode of dylng, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate tnterval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) & SHALL CELL CARCINOMA OF LUNG 6 MONTHS Examiner Due to (or as a consequence ot): Physician/Medical Examiner TO BRAIN and Ltransit METS law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequenca of) physician ar s the burial-t P.O. Box 68760. UE DUT + PE Due to (or as a consequance of) 65 ettending p signed by the e 23b. Did tobacco uas contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 XYss 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24e. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 IX Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 28a. Date of Injury (Month, Dey Year) funerel 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After ! 1 Neturel
2 Accident 5 Pending investigation hin 24 hours after death. the Funeral Director: Af mpletely filled in by the fu death. 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Sulcida 28e. Placa of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 4 Homicide 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, end due to the cause(s) and manner stated. Medical (Check only one) To the Complet \$ 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 2 AV4635427 AUGUST 1999 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 OWINGS GATE RD. # 202 DWINGS MILLS MD. ROBERT D. THOMPSON MD 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

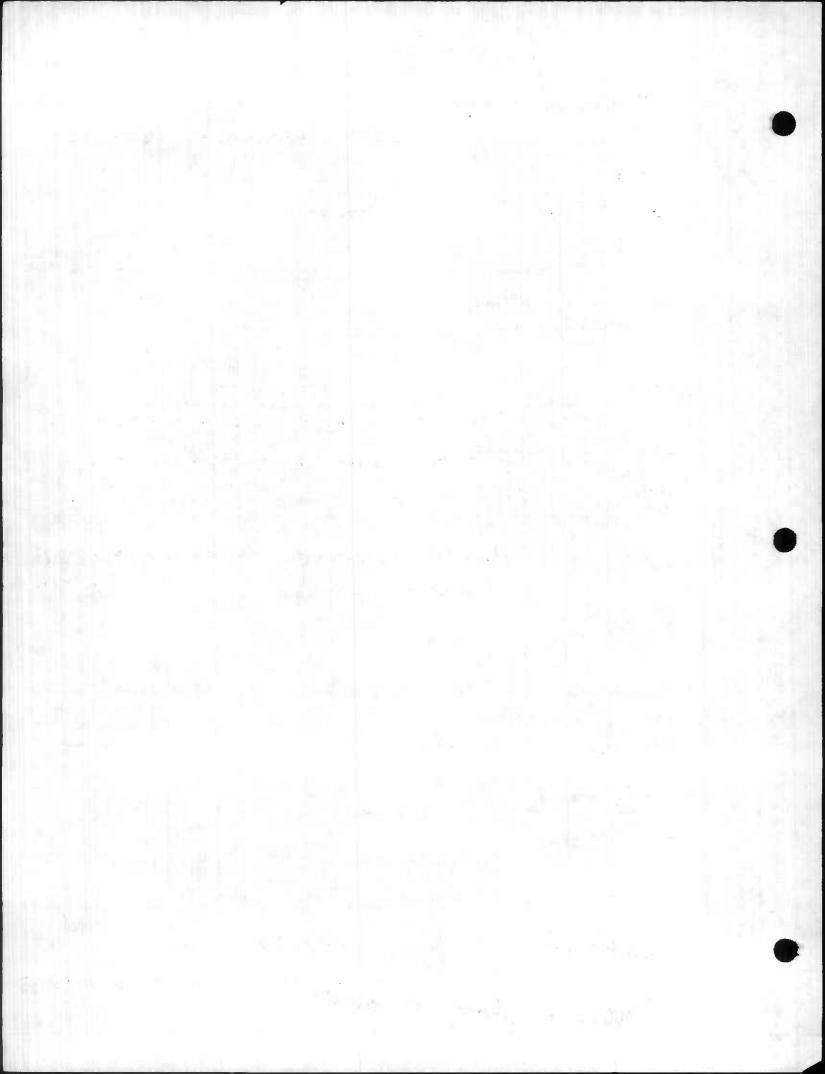
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State of Maryland / Department of Health and Mental Hygieneg 9 25454

						Cert	ificate of	Death	,	Reg. No.	23434	
			1. Decedent's Name (First, Middle, L				•		2. Date of Der Month		3. Time of Death	n
	Physic /Medi		EUZABET	H APA	ms				AUGUST		999 1:00 P	m
	Exami		4a Facility Name (If not institution, g					4b. City, Town, or	Location of Death			
			NONTHWEST	1-1058 ITAL	- CE	NTEI	2	KANDAL	LSTOWN	BAL	MORE	
	Funeral Director				e (In yrs. last 92		If Under 1 Year Months Days			y, Year)	9. Birthplace (State or Fore Country) WELDON, NC	
	P R		10a. State 10b. County		10c. City, T	own or Loc	ation				10d. Inside City Lim	nits
	ha Many Ba-1 sho	Director		/A			BALTIM	ORE			1 ½) Yes 2	No
	ar death with the Marylan thems 23s or 28s-f show one mant be notified at	rai Dir	10e. Street and Number 891.4 MAPLEBROO				10f. Zip Code 2 1.1.33			10g. Citizen of V	5 • A	
21215-0020	# 8 E	by Funeral	11. Merital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:		H	as Decedent of Yes, specify Cut	oan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - American Indian, k, White, etc. BLACK	
5-0	72	Completed	15. Decedent's I (Specify only highest g		1	(Give k	nt's Usual Occu	during most of wo	orking	16b. Kind of Bu	siness/Industry	
121	within ene.	idm i	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	O NOT use retire	od)				
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Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Fyneral Service Lig	2 11		22.	Name and Addr	ess of Facility	OWELL F	UNERAL	HOME	
			234 Part1. Enter the disease, or co	polications that source	I the death - F	46	OOLIBE	RTY HGH	TS.AVE	BALTIM	ORE, MD2120	7
S	Physician		shock, or heart failure. List onl	y one cause on each li	ne.						Interval Between Onset and Deeth	
	/Medical Examiner		Immediate Cause (Final disease or condition	. AC	UTE	m	YOCAA	-DIAZ	INFAC	CTION	1 Hours	2
	LAditimer	Je.	resulting in death)	41	Due to (or es						YEAR	
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68760,	ificate be executed g physician and es the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (or as							
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00	death of for	5	Part II. Other significant conditions	contributing to death b	ut not resultin	a in the un	deriving cause o	iven in Part I.	23b. Did 1	obacco use cor	ntribute to the cause of dea	nth?
, P.O.	requires that the death cert seen signed by the attendin hould be deteched for usa	by Physician/M							10	Yes 2 No	3 Probably ∮9€nkn	own
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ita	sician: The law certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?					26. Place of De	eath (Check only o	ne)		
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o uo	nding Ph hth. r: After th e funeral	atlon: T	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28	b. Time of fnjury	28c. Inju Wo M 1	ry at ork?]Yes 2∐No	28d. Describe h	now injury occurr	ed	
Division	or Atta	Certification:	3 Suicide 6 Could not determine		ury - At home c. (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tow		er or Rural Route Number,	
	To the Hospital or Attanding Physician: The i Within 24 hours after death. To the Funeral Diractor: After this certificata his completely filled in by the funeral director, page	edicai C		and manner etc	examination	and/or inve	stigation, in my	opinion, death occ	turred et the time,	date and place,	and due to the cause(s)	
	o the omple	Me	29b. Signature and title custifier			-	29c. Licen	se number		29d. Dete signe	d (Month, Day, Year)	
	H S H Ö		AL M	D			D	17587		AUGUS	5 10, 1999	ì
			30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type, P	rint) OLD Co	OUNT RO	RANG	DALLST	SWN MD 211	33
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 3 19	99 32 pogistro	ar's Signature	<i>b</i> .	spork		7		S (Month, Day, Year) T 10, 1999 SWN, MD 211	1
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State of Maryland / Department of Health and Mental Hygiene

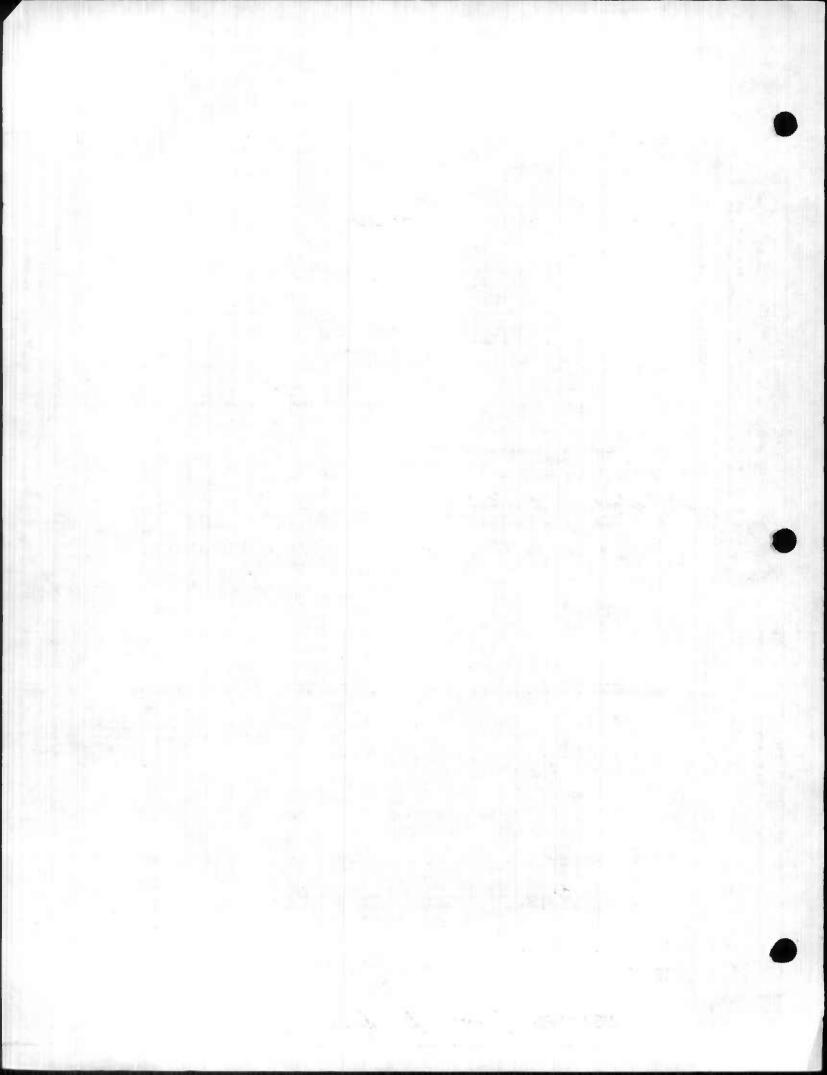
Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death ASBURY Month Dev Physician VENNIF AUGUST 10, 1999 /Medical 4:45 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ELDERCARE NETWORK SEVERNA PARK ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Hours 83 Yrs. JULY 9, Director 231-14-7180 1916 VIRGINIA **Usual Residence of Decedent** the Meryland 10a. State 10b. County 10c. City. Town or Location rthan "natural", or Itama 23a or 28a-f ahow the Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3820 WEST BAY AVENUE 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yea 2 120 No If Yes, Give Year or Detea: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indien. 11. Maritat Status permit. Pages 1 and 2 should be filled within 72 hours effer a Department of Health and Mentel hygiene. Interportant, if them 27 is marked other than "natural", or have they or other traument. Bleck, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify WHITE P 3 ₩idowed 4 Divorced Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GLASS INSPECTOR GLASS INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM EARLY STUMP PEURLINA 19a. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELBY SEWELL (DAUGHTER) 405 WASHINGTON BLVD., GLEN BURNIE, MD. 21061 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 8/13/99 GLEN BURNIE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 21 Signature of Funerat Service Licenses 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** URINARY TRACT INFECTION WITH SEPSIS tmmediete Cause (Finat disease or condition resulting in death) /Medical Examiner DEMENTIA Examiner LZHIEMERS physician and s the burief-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed 1 Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2□ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 2 Natural 5 Pending To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: All completely filled in by the fu deeth. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical 🔁 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 151104 INTERNAL MEDICINE 4710 PENNINGTON AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USHA SRIMARI VEMULAKONDA BALTIMORE, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

AUG 1 3 1999

ORIGINAL



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) 25456 Certificate of Death #5 PER F.H. G774 8-13-99 WR 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death **Physician** 1999 2043 hrs 4a Facility Nama (If not institution, give street and number) /Medical ac. County of Death 4b. City, Town, or Location of Death Examiner Memoria Grace Toure de Green Birth II Under 24 Hrs. 8. Date of Birth Min. (Month, Dey, Year) Hospital (In yrs. lest birthday) If Und Harford rtord 6. Sax 9. Birthplace Country) **Funeral** 10 M 28 F Days South Carolina 241940 Director Usual Residence of Dacedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23s or 28s-f show event, the Medical Examinating the notified at Philadel 1 Pres 2 □ No Directo phia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 808 12. Was Decedent Evar in U.S. Armed Forces? 19140 Funeral 23+ rie 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Biack, White, etc. 1 and 2 should be filled within 72 hours after of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Black Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed) Elementary/Secondary (0-12) College (1-4or 5+) Home maker 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Hey Hallman L 19a. Informant's Name/Relationship (Type, Print) Mae Jacobs Chaumatic 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2. Department of Health a Important: If Item 27 is any Injury or other treat Sylvia Huston 20a/Method of Disposition 2871. 20c. Location - City or Town, State thiladelphia 20c. Location - City aylor 20b. Plece of Disposition (Neme of cametery, cremetory or other place) August 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 13,1999 4 ☐ Donation 5 ☐ Other (Specify) Inicatel 22. Name and Addrass of Facility Dunglass Funeral 21. Signeture of Funarel Service Ligensee 1701 Me Cullah St., Baltimor e, MO121217 23a. Fart1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical immediate Cause (Final UDDEN DIAC disease or condition resulting in death) Examiner Due to (or as a consequence of): ETERIO SCLEROTIC ERTENSIVE physician end the burial-transit Examin Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) ARDIOVASCULAR Physician/Medicai Dua to (or as a consequenca of): 88 USB Part II. Other significant conditions contributing to/death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detac þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. tnjury et Work? After

ne Hospital or Attending n 24 hours after death. ne Funeral Director: Afte

AUSTON, LELA

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Maryland 21215-0020

Baltimore,

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicida

29a. Certifier

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of

1 Yes 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 No

28d. Describe how injury occurred

281. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, end due to the cause(s) and manner as stated.

2 Medical Exeminer: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signati

29c. Licensa number

29d. Date signed (Month/ Dey, Year)

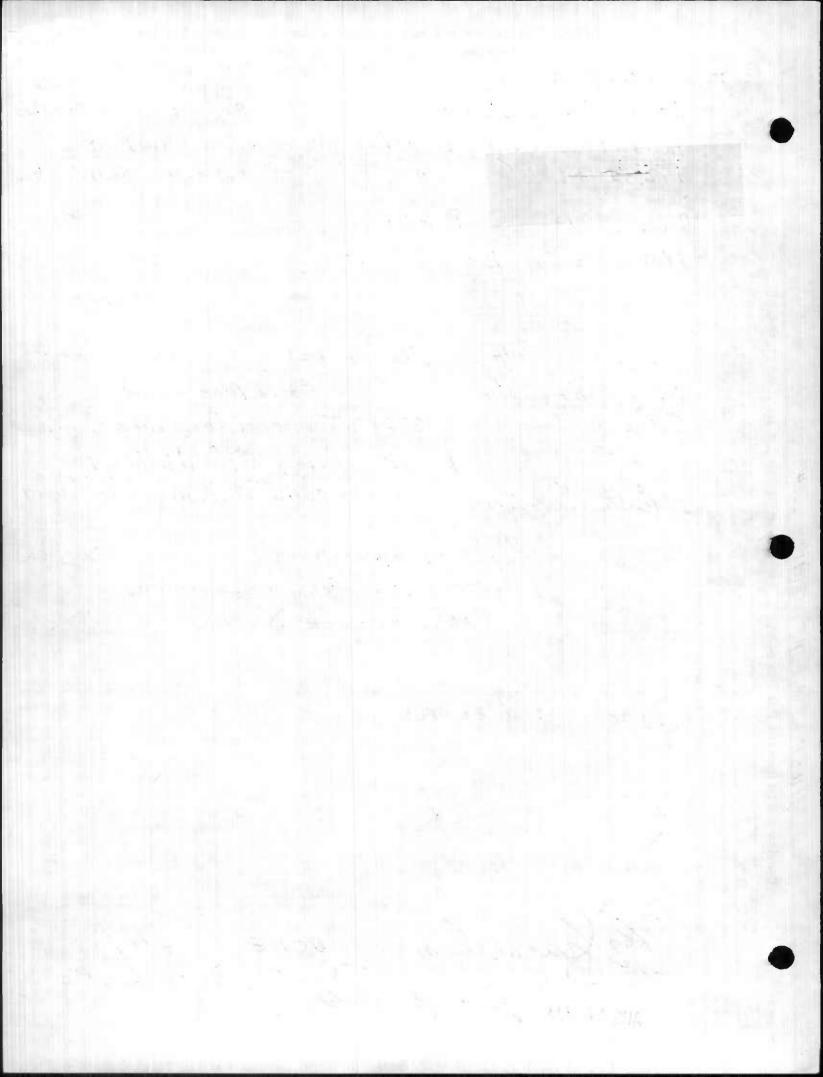
who completed cause of death (Item 23e) (Type, Print)/

State Registrar

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ENN ST. EK.M.D. 2. Redistrats Signature

To the Within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#1 PER MD. G774 8-13-99 J.A. Certificate of Death 1. Decedent's Nama (First, Middle, Last) LACY T. BOWEN, SR. 3. Time of Death 2. Data of Death 450 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City Church Home Hospital Hours Min. 8. Date of Birth (Month, Day, Year) 01 04 1905 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 □ F 94 213-09-4115 Virginia 10a. Stata 10b. County 10c. City, Town or Location 10d. toside City Limits Maryland Baltimore Co. 1 Yes 2 XNo N/A 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2603 Lodge Farm Road 21219 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3th Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 8th Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Susie Scott Siles Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgine Bowen/Daughter 2603 Lodge Farm Road, Baltimore, Maryland 21219
of Disposition (Name of Date 20c Location - City or Town, Stata 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Oaklawn Cemetery 8/10/99 Baltimore Co. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility William C. Brown Community Funeral Home 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 21217 shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) MAZNUTRITION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last 23b. Did tobacco usa contributa to the cause of death? 1 | Yaa 2000No 3 | Probably 4 | Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpetient 2 ER/Outpetient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

sician and buriel-transit physician a Box 68760 Physician/Medical 98 987 Division of Vital Records, P.O. signed by t Completed peen Be To this Certification: of or Attending Parties of the Country of the Count After

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/Medical

Director

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Examiner

Funeral

Director

7 is marked other than "nature", or heme 23e or 28e4 show traumetic event, the Medical Examinar must be notified at

Hygiene. other than

pernit. Pages 1 and 2 should be filled Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, It

Physician

/Medical Examiner

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Baltimore, Maryland 21215-0020

Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case reterred to medicat axaminer? 1 ☐ Yes 2 ☐ No 27. Menner of Death t Matural 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and magner stated. (Check only

29c. License number

29d. Data signed (Month, Day, Year)

State Registrar

31. Date tiled (Month, Day, Year) AUG 1 3 1999

29b. Signature and title of certified

32. Registrar's Signatura

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

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TICHLAND AVE. BACTIMONE, SID 21224

DHMH 16 Ray 6/95

To the Hospital within 24 hours o To the Funeral E Hospital

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Day Molly A 4.25am 1999 BACOTE August 11th 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) BonSecour Hospital Baltimore NA If Under 1 Year H Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months 1□M 2□F Yrs. 217-40-2611 53 09-16-45 MD Usual Rasidanca of Dacedent 10a Stata 10b. Count 10c. City. Town or Location 10d. Insida City Limits X Yes 2 □ No MD NΔ Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 645 N. Calhoun Street Apt #3 21217 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 220 No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) 9th Grade Collega (1-4or 5+) Housekeeping Private Duty 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Melvin Hubbard, Sr. Clara Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 21213 19a. Informant's Name/Ralationship (Type, Print) 1737 East North Avenue Baltimore, Maryland Melvin Hubbard 20b. Place of Disposition (Name of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 20a, Method of Disposition Murial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Kings Mem. PK. Cem. 08-16-99 Randallstown, MD 22. Nama and Addrass of Facility Baltimore, Maryland 21202 21. Signature of Funarai Sarvica Licensaa WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the diseasa, or complications that caused the daith bonot antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one ceusa on each line. Approximate Interval Between Onsat and Death Immediata Causa (Final disaesa or condition rasulting in daath) Endstage Liver Dua to (or as a consequence of): Pleural Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaasa or Injury Ascites Abdominal thet initiated evants resulting in daath) Last Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 ☐ Yas 2 ☐ No 1 Yas 2 No 25. Was casa rafarrad to medical axaminer? 26. Placa of Death (Check only ona) axaminer? 1 ☐ Yas 2 ☑ No Hospital: Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Dey Year) 27. Manufer of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yas 2 ☐ No invastigetion 2 Accidant 6 Could not be determined 3 Suicide

Box 68760. Division of Vital Records, P.O.

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Physician

/Medical

Examiner

Directo

Funeral

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Peges 1 and 2 should be filed within 72 hours aftar death with the Manyland nent of Heelth and Mental Hygiene.

Instit if ten 27 is marked other than "natural; or items 28 or 28=4 show my or other transmitter may be another transmitter may be notified at my or other transmitter event, or a Mandinal Examiner may be notified at

permit. Peges Department of important: if it any injury or o

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Certification:

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(Check only one)

29b. Signatura and titla of certifier

31. Data filed (Month, Day,

Human Lider MP

29a. Certifier

Examiner

Baltimore, Maryjand 21215-0020

State Registrar

House officer

28e. Plece of Injury - At homa, ferm, street, factory, office building, atc. (Specify)

1 Certifying Physicien: To the best of my knowledge, death occurred at tha tima, data and place, end due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. 29c. License number

29d. Date signed (Month, Day, Year)

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281. Location (Street end Number or Rural Routa Number, City or Town, State)

70. Name and eddress of person who completed causa of deeth (Item 23e) (Type, Print)

w. Baltimore 2000

32 Projetrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Physician-Kobert 11,1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva straat and number) 4c. County of Daath Examiner Bultmore City GERRAL HOSPITAL 1akyland If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours 1 MM 2□ F 217-24-6549 a Yrs. Director Usual Rasidanca of Decedant with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health end Mental Hygiene. Important: or items 23a or 28a-f ahow important: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Madical Examiner must be notified at Baltimore 1 Yas 2 No Directo wy NA 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 21 AZU rechen Funeral Peges 1 and 2 should be filed within 72 hours after death 12. Was Decedant Evar in U,S. Armed Eerces? Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, etc. 11. Maritai Status 1 Tes 2 No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Coilega (1-4or 5+) PRRVISO 5+1 - ban -Rr 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be 0 SNEEL LORENCE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Hd. Balto. 21215 Upserite DRO+ 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Othar (Specify) any Injury CRUSS TOROST 21. Ign tura of Funaral Sarvice Licent 22. Nama and Address of Facility march Nera 51512 4300 Wabazh 23a. Pa I. Entar that saasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shorts, or heart in ure. List only one cause on each line. Approximate Interval Batween Onsat and Death Physician /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consaquanca of): Examiner ettending physician end for use as the bunal-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): Box 68760. certificete be Physician/Medical Dua to (or as a consequença of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? signed by to 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? has 2 12 No 1 ☐ Yas 2 ☐ No I or Attending Physician: efter death. Director: After this certific Be 25. Was casa rafarrad to medical 28. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 10 1 | Inpatiant 2 DER/Outpatient 3 | DOA 28a. Data of injury (Month, Day Year) funeral 27. Mannar of Death 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred Certification: 1 DNatural 5 Panding invastigation 1 Yas 2 No 2 Accident 8 Could not be 3 ☐ Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) filled in by 4 Homicida To the Hospital within 24 hours of To the Funeral I Hospital edicai 29a. Cartifiar 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

Records, P.O. Division of Vital

> State Registrar

31. Data filed (Month, Day, Year) AUG 1 3 1999

29b. Signatura and titla of certifiar

(Check only one)

3. Registrar's Signatura

m.D.

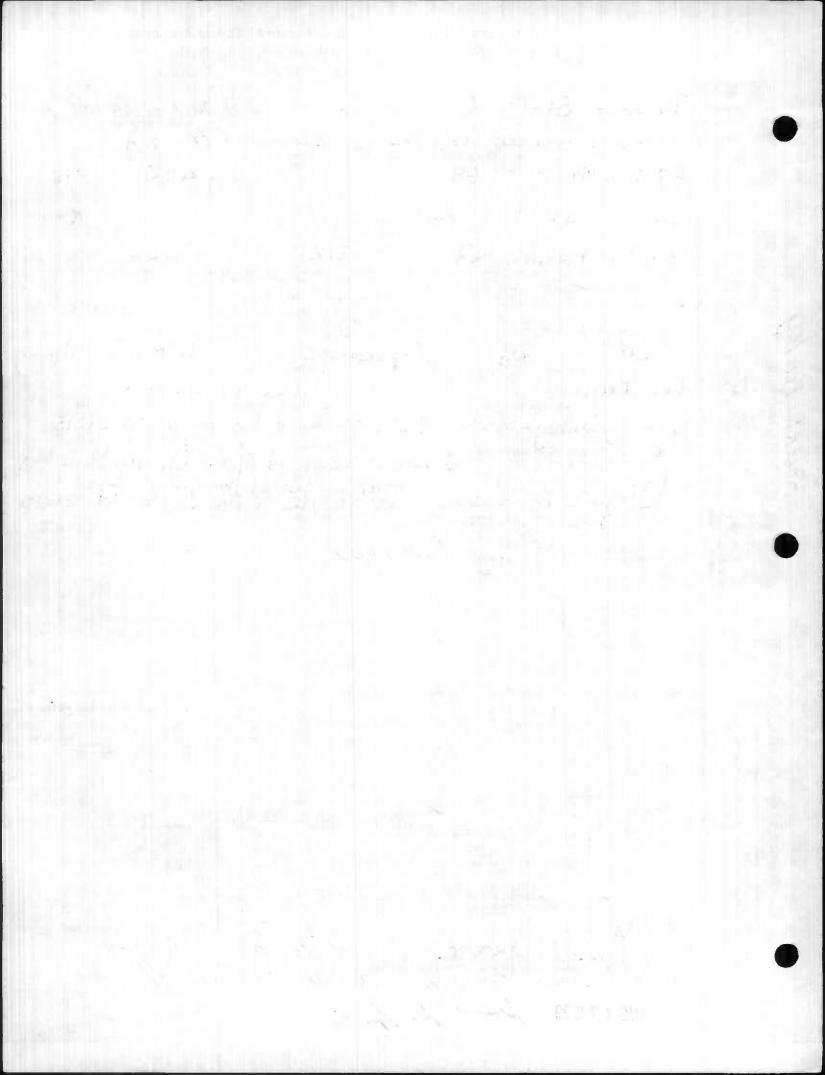
30. Nama and addrass of person who complated causa of daath (item 23a) (Type, Print)

DAUR

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data şigned (Month, Day, Year)

band General Hospital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25460 Certificate of Death AMENDED ITEM 23a PER MD G774 8/13/99 AH 2. Date of Death Month **Physician** reorge Hua /Medical 4b. City, Town, or Location of Death Facility Neme (If had institution, give street and number) 4c. County of Examiner mor 5. Social Security Number 6. Sex 7: Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10/M 20 F Days Director Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Completed by Funeral Director and Stre et and Number 10f. Zip Code 10g. Citizen of What Count death with 7 is marked other than "natural", or items 23s or treumstic avant, the Medical Examinar must be a 0 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after or nent of Hauth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Ner Inty or other theumatic avent, the Model Emericanty 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Barus 110 15. Decedent's Education ify only highest grade completed) 16a. Decedent's Usuel Occupation t6b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT, use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Baltimore, Maryland 17. Eather's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 0 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Nymber or Rural Route Number Wit ,2 0 20b. Place of Disposition (Name of Acemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tery, crema 1 Burial 2 Cremetion ortant: If I 3 Removel from State 16 Important: If any injury or page Department 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility 12 a Ave. WiNorth Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Thrive Zilwe 40 Examiner Due to (or as a consequence of) Physician/Medical Examiner ATHEROSCLEROTIC HEART DISEASE sician and buriel-transit The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). physician at the buriel Box 68760. Due to (or as a consequence of): 80 080 23b. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Sthknown ate hes been signed in page 2 should be det à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? After this certificate has 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Physicien: director, 25. Was case referred to medical examiner? edical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Impatient 2 ER/Outpatient 3D DOA funeral 27. Manner of Death 1 Natural 2 Accident 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month. Day Year) 28c. Injury at Work? 5 Pending investigation or Attending 1 ☐ Yes 2 No within 24 hours effer death. To the Funeral Director: All completely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

AUG 1 3 1999

Miller

31. Date filed (Month, Day, Year)

Raymond

Miller

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Main Street Stute

32, Registrar's Signature

5.

MP

Sparks

D47683

8/12/99

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Physician Month ames 1999 0250 AM August 10 /Medical Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner V S 9 , an Sburg ter. more more If Under 1 Yeer If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birthplace (State or Foreign Funeral 7596 1 M 2□ F Deys 78-18-Director YOV. Vashington, D.C Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 Yes 2 □ No Marylang 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 6 SOY "natural", or Items 23a death v do 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece Rece - American Indian, Black, White, etc. 11. Maritel Stetus the Medical Examiner filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒No Specify: þ Specify! 3 Widowed 4 □ Divorced Da Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) trsumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental a 19e. Informant's Name/Relationship (Type, Print) (SISTET 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Haalth and Important: If Item 27 is m any injury or other trsum atherin 7a1 Va 10, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ores 22. Name end Address of Fecility 21. Signature of Funeral Service Licansee Joseph era W. North AUR. ass, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, List only one cause on each line. Approximete Interval Between Onset and Death **Physiclan** TIMEE /Medical Immediete Cause (Final . ACUTE CORONARY THROMBOSIS MINUTES disease or condition resulting in death) **Examiner** Due to (or es e consequence of): Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): P.O. Box 68760, Physician/Medicai Due to (or as a consequenca of): use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yas 2 ☐ No 3 Probably 4 ☑ Inknown GANGRENE OF FEET Division of Vital Records. þ 24b. Were eutopsy findings evailable prior to director, page 2 should Completed 24a. Wes an autopsy performed? completion of cause of deeth? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 28. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Menner of Deeth Medicai Certification: Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Watural 2 Accident 5 Pending investigation To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the forms. death. 1 Tyes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Exerce Deborah Pierce August 10, 1999

State Registrar

2. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

7220

Park Heights Avenue, Baltimore MD

cartest of Stone Briefall Pola 189 500 1 For 1 1 19 Alle 19 9 James & James

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 99

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28-4 show any injury or other traumatic event, Ita Mouleal Expriner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ian cal	1. Decedent's Name (First, Middle, Last) ANNA BOSS					A U G U S	Day	Year 99	3. Time of Death 18.45 pm
ner	4a. Facility Name (If not institution, give street end number COPPER RIDGE	")			b. City, Town, o	Location of Deet		of Deeth	OLL
	5. Social Security Number 212 34 6415 Usual Residence of Decedent	ge (In yrs. lest birti 89	nday) If Under Months		If Under 24 Hi Hours Mi		th y. Year) 5, 1910	9. Births Cour Ma	place (State or Foreign ntry) ryland
	10a. State 10b. County	10c. City, Town	or Location					1	10d. Inside City Limits
ctor	Maryland Howard	Marri	ottsvill	.e					1 ☐ Yes 2 💢 No
Dire	10e. Street and Number		10f. Zip				10g. Citizen of		ntry?
Fai	2650 Thompson Drive			2110			U.S		
by Funeral Director	11. Maritel Status 1 Never Married 2 Married 1 Yes 2 Mill Yes, Give 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes, Give Year or Dates:	? No	13. Was Deced	ify Cube	n, Mexican, Pue	Specify Yes or No irto Rican, etc.)		ck, White,	etc. nite
	15. Decedent's Education	16a.	Decedent's Usua	I Occupi	ation		16b. Kind of 8		
Completed	(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or	5+)	(Give kind of wor life. DO NOT us	k done d e retired	luring most of w)	orking			
Соп	8th		School T	each			Catho1		chool
Be	17. Fether's Name (First, Middle, Last)					ame (First, Middle,		ne)	
To	John Paul					Minnie He			
	19a. Informent's Neme/Relationship (Type, Print)					Rural Route Numb			
	Anna M. Bezelik / Daughte 20e. Method of Disposition	20b. Place of	50 Thomy Disposition (Nerr	ne of		Date	20c. Location		d. 21104 own. State
	1 Removal from State 4 □ Donation 5 □ Other (Specify)		ross Cer	mete	ry	8/16/99			Maryland
	21. Signature of Funeral Servica Licensee	ch.	22. Name and			Gonce E way Balt			
	23a. Pert1. Enter the disease, or complications that ceuse shock, or heart tailure. List only one cause on each	d the death. Do notine.							Approximate Interval Between
	Immediate Cause (Finat disease or condition resulting in death)	sided	Str	0/c-e					onset and Death Weeks
Jer	(Due to (or es e c	onsequence of):					1	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):					1	
cian/Medical	Cause (Disease or Injury that initieted events resulting in death) Last	Due to (or as e co	onsequence of):					-	
lan/N	d								
	Part II. Other significant conditions contributing to death the Alzheimer of Disc		the underlying ca	ause give	en in Part I.		lobacco use co Yes 2 No		o the cause of death?
by	Tilg weimer 3 Dis	ease				-			
Completed by Phys						24a. Was perfo	an autopsy med?	av	ere eutopsy findings eilable prior to impletion of cause death?
Соп						10	res 28 No	18	☐Yes 200 No
Be	25. Was case referred to medical examiner?			1 2		eath (Check only o	ne)		
2	1 Yes 2 No Hospital: 1 □ Inpati				4 Nursing	Home 5 ☐ Resid			(y)
ation	27. Manner of Death 1 ★ Natural 5 □ Pending (Month, Description) 2 □ Accident investigation		me of 29 jury M	Bc. Injury Work	at t? Yes 2 □ No	28d. Describe	now injury occur	rred	
Certific		jury - At home, fan tc. <i>(Specify)</i>	m, street, factory	, office		28f. Location (: City or Tox		ber or Rura	al Route Number,
edical Certification:	29a. Certifier (Check only one) Certifying Phyatctan: To the best 2 Medicat Examiner: On the basis of and menner st	of examination and	deeth occurred a for investigation,	t the tim	e, dete and place pinion, death occ	ea, and due to the curred at the time,	cause(s) and m date and place,	enner es s and due to	tated. the cause(s)
M	29b. Signature and title of certifier Emestine Who	ght, N	D 290	License	274	0	August	12	Dey. Year) 1999
	30. Name and address of person who completed cause of a Ernestine Wright, MD,			oad	, Syke	sville,	MD 2	21784	4

SH DHMI

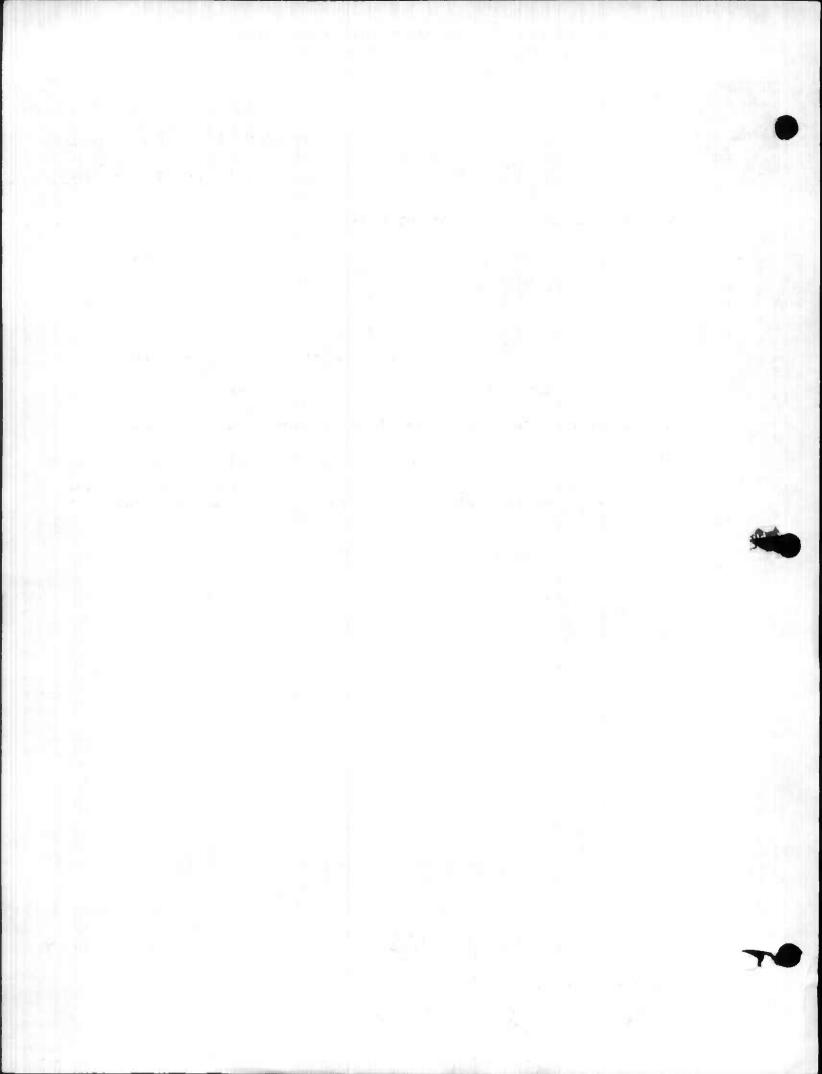
Registrar

State

31. Date filed (Month, Dey, Year)

AUG 1 3 1999



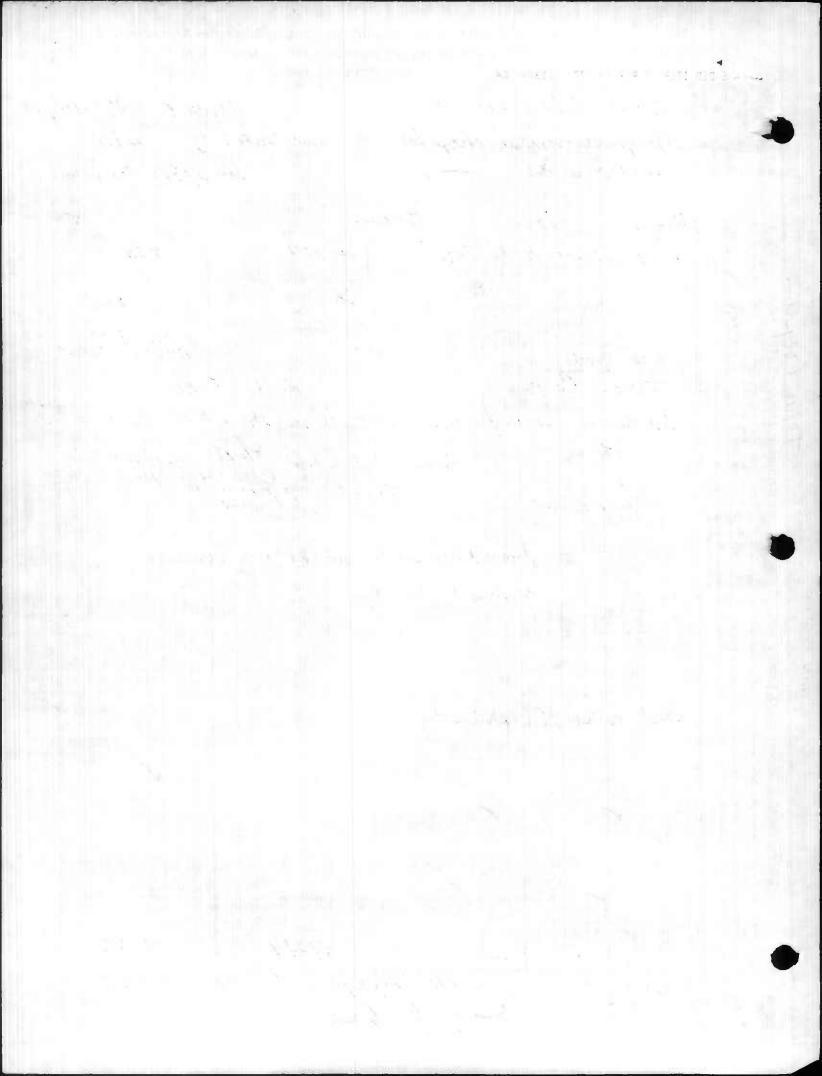


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Registrar **DHMH 16 Rev 6/95**

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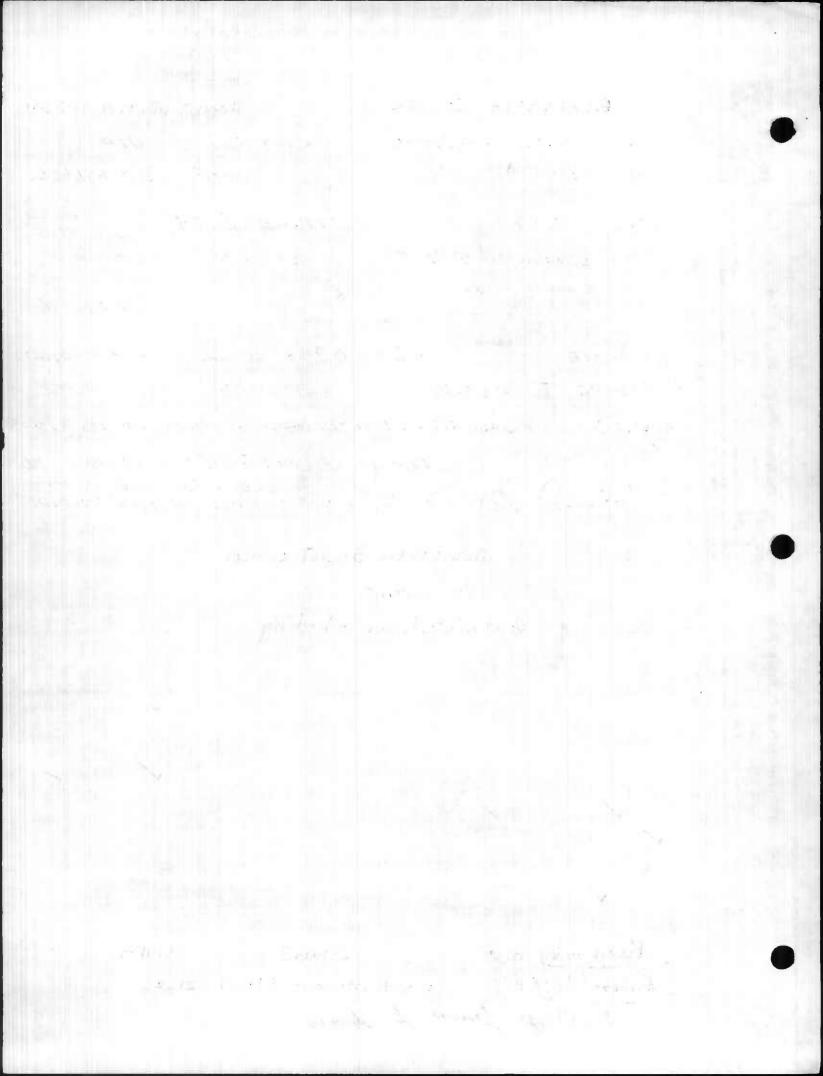


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day Vesi **Physician** BOBBYETTA COOPEZ August 11th 1999 12.05am /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner ON SECOURS BALTI MORE
If Under 24 Hrs. 8. Date of B HOSPITAL 8. Date of Birth (Month, Day, Year)
TULY 13, 1944 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1□M 281F Months Hours 212-46-8957 Usual Residence of Decedent Director MARYLAND the Maryland 10c. City, Town or Location 10s State 10b County 10d. Inside City Limits 28a-f ahow traumetic event, the Medical Examiner must be notified at t ØYes 2 □ No Director MARYLAND 10e. Street and Number Log. Citizen of What Country? 1955W. items 23a EXINGTON STREE USA. Funeral deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status permit. Pages 1 and 2 should be filled within 72 hours after or Department of Health and Mental Hygiena. If them 27 Is marked other than "natural", or then 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: ρ BLACK 3 Widowed 4 □ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 THGRADE CHILD CARE PROVIDER SELF-EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) CLARENCE BOONE STINNETTE JANICE 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1955 W. JANNICE D. TOLIVER (DAUGHTER) LEX INGTON ST. BALTIMORE, MD. 2/223
ma of Date 20c. Location - City or Town, State iny Injury or other 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 12 Burial 2 Cremation 3 Removel from State 7-99 GLENBURNIE, MD. HILL CEMETERY Other (Specify) gt Funeral Service Lice 22. Name end Address of Fecility

JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIHORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respirato shock, or haart failura. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Metastatic Breast cancer /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Pheumonia **bunial-tran** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that Initiated avants resulting in death) Last pue physician Records, P.O. Box 68760 Physician/Medical the Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown á s bean signed to should be deta g 24b. Wera autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed page 2 cartificate hes 2 No 1 Yes 22 No 1 □ Ves Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical axaminer? Be 26. Pleca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Pending 1 Yas 2 No investigation 2 Accidant 3 Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Spacify) 4 | Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 08/11/99 038993 complated cause of daath (Itam 23a) (Type, Print) MD Street 2000 WBaltimore 32. Registrar's Signature State AUG 13 1999

Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month Day August 81,254.m 10 1999 Kelly Cook /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** GLEN BURNIE ANNE ARUNDEL NORTH ARUNDEL HOSPITAL If Under 24 Hrs. If Under 1 Year Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months XXM 2□ F Hours Yrs. 1/3/1927 Director 218-22-8796 72 West Virginia Usual Residence of Decedent the Maryland 10a State 10b Count 10c. City, Town or Location 10d Inside City Limits than "natural", or items 23s or 28s-f show the Medical Example: must be notified at 1 ☐ Yes 2 No Director Maryland Glen Burnie Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 514 Joy Circle 21061 U. S. A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 No
If Yes, Give
Yeer or Dates: Black, White, etc. 1945 1 Never Married 2 Married 1 Yes 2 No Specify: 1947 À 3 ☐ Widowed 4 ☐ Divorced "netural". White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: if tem 27 is marked other that any Injury or other traumatic event, that once. 12 New Construction Pipe Insulator 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Kelly Cook Bertie Goode 2 19a, Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Joy Circle Glen Burnie, Joan Mary Cook (Wife) Maryland 21061 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 8/13 XXBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cemetery 1999 Crownsville, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Singleton Funeral Home PA 1 Second Avenue S. W. Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final conces disease or condition resulting in death) home **Examiner** Due to (or as a consequence of): physician and the burial-transit Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 8 Physician/Medical Due to (or as a consequence of) attending for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 3 Probably 4 Unknown 1 Yaa 2 No bengis p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen : page 2 NO No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; 25. Was case reterred to medical Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No edical Certification: To 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Maryland 21215-0020

altimore,

Box 68760.

Records, P.O.

Division of Vital

Pegistrar
DHMH 16 Rev 6/95
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30. Name and add

31. Date filed (Month, Day, Year)

32. Register's Synature

4. Apocks

MA

Hospital

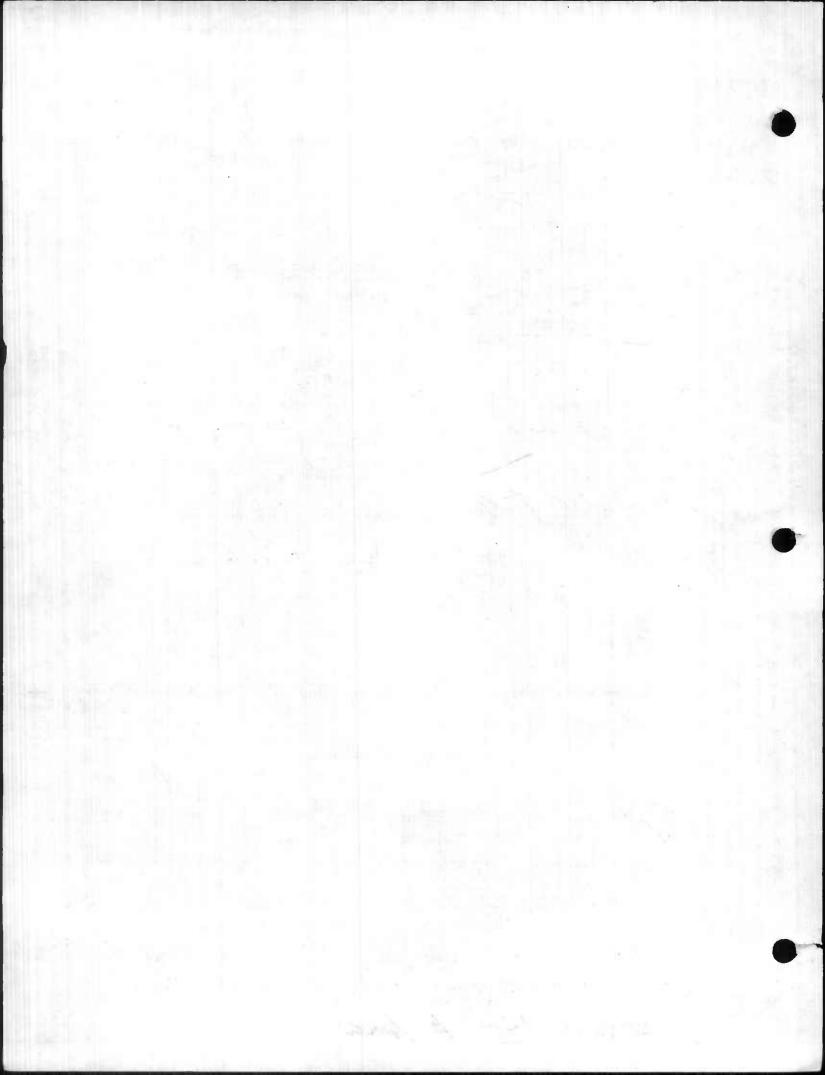
of person who completed cause of death (Item 23a) (Type, Print)

301

ORIGINAL

Drive

Busne. ms. 21061



Physicia	an	MEND ITEM: #23 PA AMEND ITEMS: #23 PAR 1. Decedent'a Name (First, Middle, Li JAMES					2. Date of De Month	Day	Year 3. Time of Deat
/Medic Examin		4a Facility Name (If not institution, gi	ive street and number)			4b. City, Town, or I	AUGUST Location of Death		
		SINAI HOSPITAL				BALTIMOR		N/A	
Funeral Director			Sex 7. Age 7. Age 38	(In yrs. last bi	rthday) If Under 1 Yea Yrs. Months Day		8. Date of Bir (Month, Da OCT 23	th ly, Year) 1960	Birthplace (State or Fore Country) MD
r 28a-f show notified at	tor	10a. State ND N/A		10c. City, Tov BALT	n or Location IMORE				10d. Inside City Lin 1X Yes 2□
23a o	al Director	10e. Street and Number 2938 W. COLDS	SPRING LAN	E APT	B 2121			10g. Citizen of USA	
or hams aminer m	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent E- Armed Forces? 1 Yes 2 No. If Yes, Give		13. Was Decedent of If Yes, specify Cu	ban, Mexican, Puert	pecify Yes or No o Rican, etc.)		ce - American Indian, ck, White, etc.
A Ex		3 Widowed 4 Divorced	Year or Dales:	160	Decedent's House Con	unation		16h Kind of B	BLACK
the Medic	Completed	15. Decedent'a E (Specify only highest gr Elementery/Secondary (0-12) 12th	College (1-4or 5+)	Decedent's Usual Occi (Give kind of work don life. DO NOT use retir ACTOR TRA	e during most of wor red)			usiness/Industry Y TRUCKING
ontal Hyg and other c event, I	To Be Co	17. Father's Name (First, Middle, Last JAMES COUSER	1)			18. Mother's Nam	ne (First, Middle,	, Maiden Sumen	ne)
27 is mari	-	19a. tnformant's Name/Relationship MARIE JOHNSON-		19	b. Mailing Address (Street BESAN CO			er, City or Town,	
ant of Hea nt: If Isam ry or othe		20a. Method of Disposition **Description** **Donation 5 Other (Special Control of the Control	Removal from State	cemete	of Disposition (Name of ary, cremetory or other parties TUS MEMOR.		Date 81699	20c. Location -	City or Town, State
	\vdash	23a. Part1. Enter the disease, or con	nplications that caused t	the death. Do	4300 WA	UNERAL F BASH AVE ying, such as cardiac	E. BAL	TO. M	D 21215 Approximate
Medical kaminer	ier	23a. Part I. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	PNEUMONIA PNEUMONIA C	COMPLICATION	4300 WA	BASH AVE	CARDIMY	rrest, OPATHY	Approximate Interval Between
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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year MICHAEL CILYK AUGUST 1999 15:40 11 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY Il Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Sept. 21,1929 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Deys Hours UKRAINE 69 Yrs. 215-30-0732 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes XXNo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12101 BUTTONWOOD LANE 21220 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No if Yes, Give Year or Dates: 1951–53 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) GENERAL MOTORS PAINTER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) DANIEL CILYK FEDORA SUHANJAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPHINE CILYK/WIFE 12101 BUTTONWOOD LANE, BALTIMORE, MD. 21220 20e. Method of Disposition 1 A variel 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) ANDREWS ORTHODOX 8/16/99 BALTIMORE, MD. 22. Name and Address of Facility LILLY & ZEILER 21. Signature of Funeral Service Licenses INC. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) ACUTE MYOCARDIAL INFARCTION 4 DAYS Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 💆 Unknown CARDIOGENIC SHOCK 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 Tes 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, Iarm, street, lectory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Box 68760. 88 for use Records, P.O. signed I page 2 : certificate Division of Vital

Examiner physician and the burial-transit Physician/Medical Be Completed by Certification: To this Aftar

Physician

Examiner

Funeral

Director

28a-f ahon

8 ma 23a

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Pages 1 and 2 should be filed within 72 hours after in and Medial Hygiene. Interfer and T is marked other than "natural", or the Iry or other traumate avent, ins would be sentioned.

Department of Important: If any injury or

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

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Funeral

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the Maryland

death v

/Medical

or Attanding Physician: after death. filled in by 24 hours within 2

> State Registrar

edical

29e. Certifier

(Check only

31. Date file (Coth,

29b. Signature and title of certifier

JOHN HAGE,

MD

600 N. WOLFE ST, 2. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) BALTIMORE, MD

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

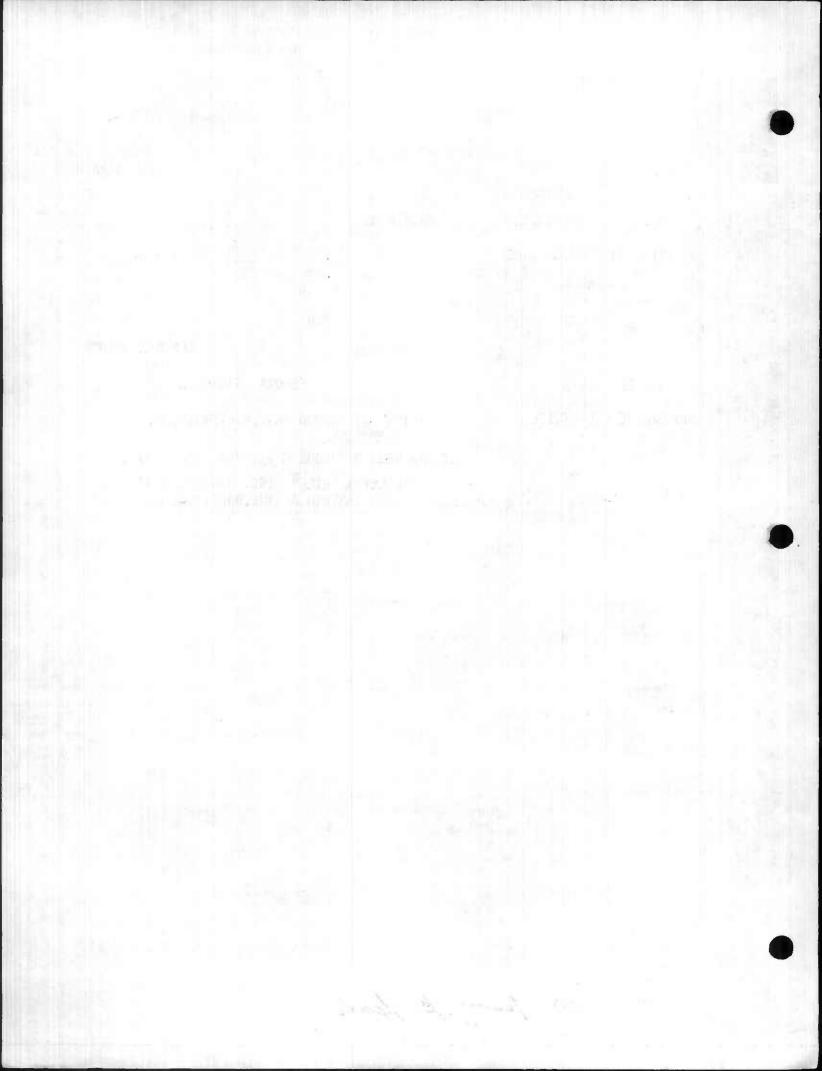
29c. License number

RES-000

AUGUST 11, 1999

29d. Date signed (Month, Day, Year)

21287



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day th Year 10 1999 ALICE CATRONE

4a Facility Name (Il not institution, give street and number) **Physician** 1700 P.M. August /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner CHURCH HOSPITAL BALTIMORE N/A If Under 24 Hrs. 8. Date of Birth (Monthy Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** . Sex 1□M 2▼F Days 213208160 Director 07/06/1926 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Baltimore Dundalk 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 5 na 23e 3307 Sollers Point Rd 21222 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Merried I Hygiens. other than "natural", or I rent, the Medical Examin Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 1 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Manicurist Hair / Beauty Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic eve Cyrus James Donnelly Carrie Viola Haugh 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Donnelly /niece 5968 Glen Falls Ave Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug 14 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Burns Hill Cemetery Waynesboro, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk onny 7110 Sollers Point Rd 23a. Part1. Enter the disease or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. Ust only one cause on each line. Approximate Onaet and Deeth **Physician** Decompensated Congestive Heart Faithure Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Right Leg Deep vein Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 22 No 3 Probably 4 Unknown MYPERTENSION Records. by DIABETES 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 TYes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division or Attanding 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1½C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28762 08-10-1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 N. BROADWAY BALTIMORE MD 21231

State Registrar

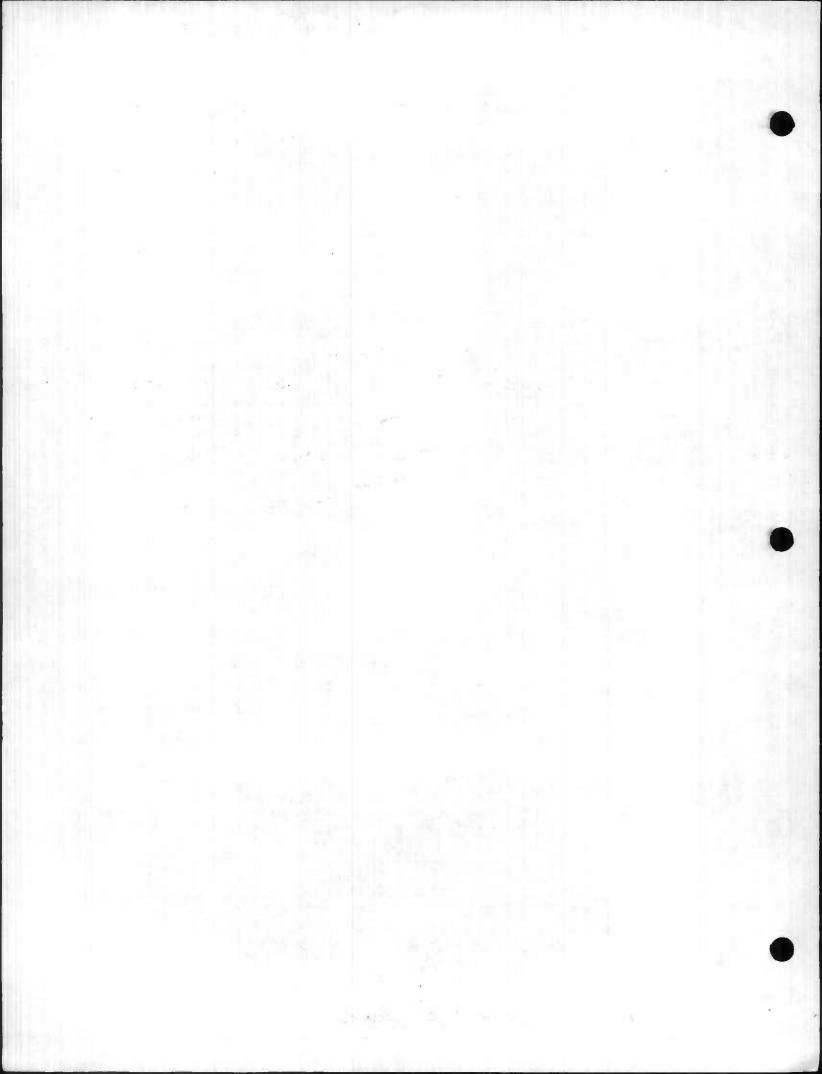
DHMH 16 Ray 6/95

AHUJA

32. Registrar's Signature

SUNIL 31. Dete filed (Month, Day, Year)

AUG 1 3 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death CARROLL end number) LMA AUGUST 4a. Facility Neme (If not institution, give street end nul 4c. County of Death 4b. City, Town, or Location of Death SANDTOWN -WINCHESTER NURSING HOME BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) Yrs. If Under 24 Hrs. Birthplece (State or Foreign Country) 1 M 2 F Days Months Hours 19/1921 220 12 7221 MARYLAND Usual Rasidence of Decede 10a State 10c. City, Town or Location BALTIMORE 10d. Inside City Limits Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 N. GILMOR STREET 21217 U.S. OF A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yas, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) STOCK CLERK RETAIL STORE UNKNOWN UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) JOSEPH CARROLL MARTHA BISHOP 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) (FRIEND) 708 WHITEMORE AVENUE BALTO., MD. 21216 ELINOR TURNER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 8/16/90 te 20c. Location - City or Town, State Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) ARBUTUS MEMORIAL PARK BALTIMORE MD. 21. Signature of Funeral Sarvica Licensag TUIS T GWYNN 22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO MD. ynn) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onset end Deeth Immediate Causa (Final ARCINOMA ETATSTATIC disease or condition resulting in death) CARCINOMA Sequentielly list conditions, if eny, laading to immadiata cause. Enter Underlying Ceuse (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case raferrad to medical exeminer? 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 2 Accident Invastigation 1 TYes 2 □ No 6 Could not be datemined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one)

Examiner and Box 68760. signed b of Vital Division Attanding death. after deat Director: ò

Physician

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Physician /Medical

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Baltimore, Maryland

Director

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Certification: To 24 hours To the within 2

State Registrar

31. Data filed (Month, Day, Year) **AUG 13**

29b. Signature and title of certifier

MADURAIL

32. Registrar Signature

30. Name and address of person who completed causa of death (item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** Month Dev GEOR 4b. City, Town, or Location of Deeth 12:15 A.M. 26 /Medical 4e. Fecllity Neme (If not institution, give street and number) 4c. County of Deeth Examiner SANDTOWN BALTIMORE WINCHESTER NURSING HOME B. Dete of Birth (Month, Dey, Year) South If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Country) Months Deys 100 M 2□ F Hours PAROLINA 214-50-0193 Director Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 23a or 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at BALTIMORE C Director Yes 2□ No MARYLAND 10e. Street and Number 10g. Citizen of Whet Country? 2 / 2 / 7

13. Was Decedent of Hispenic Origin? (Specify Yes or Noif Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 12 MOSHER STREET USA,

14. Race - American Indien,
Bleck, White, etc. Funeral 12. Was Decedenf Ever in U,S. Armed Forces? or items 11. Maritel Sfetus filed within 72 hours effer 1 ☐ Yas 2 No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced BLACK Yeer or Detes: naturel', Completed 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Flementary/Secondery (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filled w. Depertment of Health and Mental Hygien. Important: If Nem 27 I e marked other the any Injury or other trainment. ECURIT EMPLOYMENT AGENCY 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surname) Be GEORGE 2 PAUIS McCOU 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3924 RIDGE WOOD ROAD BACTIMORE, HD. 21215 of Disposition (Name of Deta 20c. Location - City of Town, State SISTER) WILLIE MAE WILLIAMS 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Mathod of Disposition Buriel 2 Cremetion 3 Removel from State Concept on 5 Other (Specify) ZION CEMETERY 8-13-99 LANSDOWNE, 40. 21. Signetury of Funerel Servi 22. Name end Address of Facility JOSEPH 2140 N. BROWN JR. FUNERAL HOME FULTON AVE. 23a. Part. Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cerdiec or respiratory errest, ck, or heart feilure. List only one cause on each line. D.2121 Approximate Intervel Between Onset end Deeth Physician /Medical Immedieta Cause (Finel 5REBRAL disease or condition resulting In deeth) **Examiner** NOMA Examiner certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseasa or Injury thet initiated evants resulting in deeth) Lest physician and s the burief-tran ULMONARY P.O. Box 68760, Physician/Medical Due to (or es e consequence of): the use as attending | Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown signed d be del Records. þ 24e. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed peen completion of cause of daeth? page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was cese refarred to medical examiner? 28. Pleca of Death (Check only ona) Other: 4 Solution Home 5 Residence 6 Other (Specify) 1 Yes 2 10 10 1 fnpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deet 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred Division 5 Pending Investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, straet, factory, office building, etc. (Spacify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

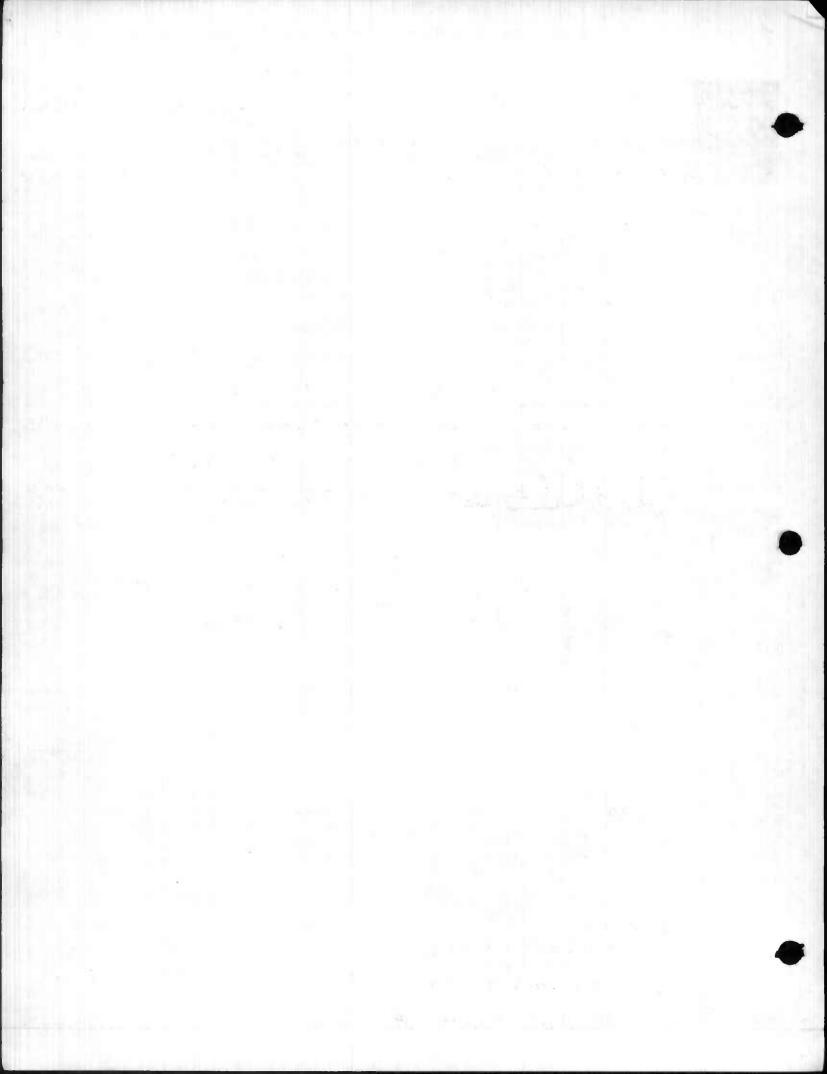
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the fime, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) 29b S d title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 1'RAB HARZAN 30. Name end eddrass of person who completed ceusa of daath (Item 23a) (Type, Print) ALTIMORE, MD21 OREMS ROAD

State Registrar

AUG 1 3 1999 **DHMH 16 Rev 6/95**

31. Dete filed (Month, Dey, Year)

32. Ragistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

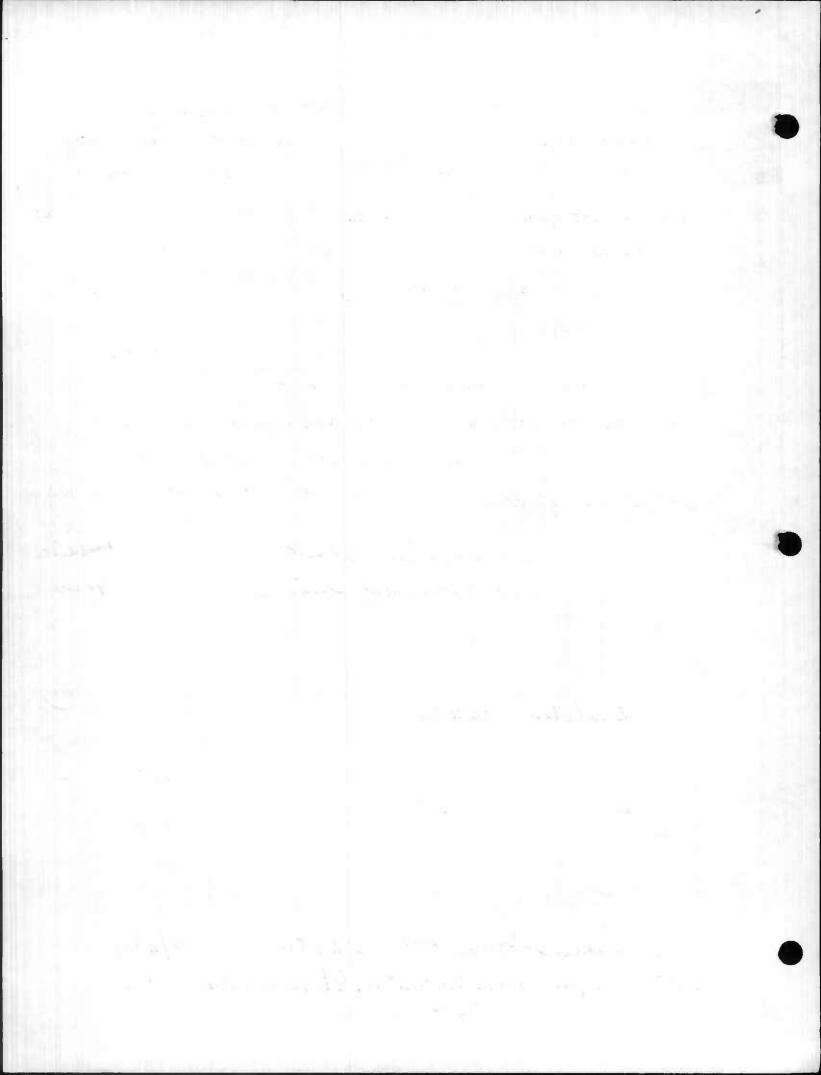
State of Maryland / Department of Health and Mental Hygiene 99

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	Funeral Director			Sex 7. Age 1 X M 2 □ F	6 (In yrs. lest bird	Yrs. If Under 1 Months	Year Days		8. Date of Birth (Month, De) MAY 19	(, Year)	9. Birth Cou MAR	place (Stete or Foreign intry) LAND
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	as Leastine						4044
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	23a or 2		1201 HILLCREEK R	OAD		10f. Zip C		1122		10g. Citizen of U.S	What Cou	ntry?
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21215-0020	filed within 72 ho Hygiane. other than "naturent, use Manical	Completed	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12)	ducation ade com <i>pleted)</i> Coilege (1-4or 5-		Decedent's Usual (Give kind of work life. DO NOT use ASSEMBL	done retire	during most of work	ing	16b. Kind of B	Business/Ir	
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Ja		TOE	LEWIS FREDRICK	Du BE	RITTON,	JR.		DORIS		K	CLEIN	
Maryland	~ ~ ~	ľ	19e. Informent's Neme/Relationship	Type, Print) (WIFI	E) 19b.	Meiling Address (Stree	t end Number or Rur	al Route Numbe	r, City or Town	, Stete, Zij	p Code)
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AUG 1 3 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Tima of Death **Physician** Month Louis Joseph Eberle, Sr. August 11, 1999 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Birthplaca (Stata or Foreign Country) 1QM 20 F Days Hours Yrs. 212-01-7383 Director 87 January 20,1912 MD Usual Rasidence of Decaden the Maryland 10a Stata 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Example; inset to notified at 10d. Insida City Limits Director 1 ☐ Yas 2 ☒ No Baltimore Catonsville 10e, Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 719 Maiden Choice Lane 21228 U.S.A. Funeral death 12. Was Decadant Evar in U,S. Armed Forcas? 1 [XYas 2 □ No If Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Orlgin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Ricen, atc.) Race - Amarican Indian, Black, Whita, atc. 11 Marital Status filed within 72 hours after 1 Navar Marriad 2 Marriad 21215-0020 natural', or WWII 1 Yas 2 No Spacify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry ith and Mental Hygiena. 27 is marked other than "r r treumatic event, the Mac Elementery/Secondery (0-12) College (1-4or 5+) CPA/Attornev Accounting altimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth lury or other traumatic even Be Frank Eberle Frances Osburne 19a. Informant'a Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Robert L. Seitz (Brother-in-Law) 1406 Midmeadow Road, Towson, Maryalnd 21286 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ₺ Burial 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If any injury or once. 8/14/99 Towson, Maryland Dulaney Valley 4 Donation 5 Othar (Specify) 22. Name and Addrass of Facility Witzke Funeral Homes, Inc. 21. Signature of Funaral Sarvice Licensae 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or companies that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only the cause on each line. Onsal and Death Physician /Medical immadiata Causa (Final SPIRATION NEUMONIA MONTHS disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, laading to immadiata ceuse. Enter Undarlying Causa (Disaasa or Injury that initiated avants rasulting in deeth) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Dua lo (or as a consequance of) P.O. 1 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? STAGE DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, ð Completed 24b. Were autopsy findings aveilable prior to complation of causa of death? 24e. Was an autopsy performed? certificata has 1 Yas 2 No 1 Yas 2 No of Vital Attending Physician: filled in by the funeral director, Be 25. Was cese rafarred to madicel axaminar? 26. Place of Death (Chack only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) s after death. P 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Deta of Injury (Month, Day Year) Medical Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Panding invastigation 1 Natural 1 Yes 2 No 2 Accidant 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide ò 24 hours a Funeral D 29a. Certifian Certifying Physician: To the best of my knowledge, daath occurred et tha tima, dete end plece, and dua to tha causa(s) and menner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, date and place, and due to the ceusa(s) and manner stated. To the Hosp within 24 hou To the Fune completely fi 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) AUGUST 12,1999 200

CATONSVILLE

21228

Registrar

State

30. Name and address of person who complated ceuse of deeth (item 23a) (Type, Print)

LANE 32. Registrar's Signature

7/1 MAIDEN CHOICE
31. Data filed (Month, Day, Year)

AUG 13

DHMH 16 Rev 6/95

Name:



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Richard E. Davis August Q 1999 2:00 A.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4003 Ritchie Highway Baltimore Anne Arundel If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 15 M 2□ F Months 228772 20 Director 68 May 26, 1931 Pennsylvania Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d Inside City Limits 28a-f ahon must be notified at 1 ☐ Yes 2 ☑ No Anne Arundel Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 4003 Ritchie Highway Herne 23a 21225 U.S. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Pages 1 and 2 should be filled within 72 hours after tent of Heelth and Mental Hygiene. nt: If Nem 27 Is marked other than "natural", or He 1 ☐ Never Married 2 ☑ Merried Baltimore, Maryland 21215-0020 1 Ves 2 No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Years Mortician Funeral 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 8 Amecia Moyer Robert Davis 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Heelth or Important: if them 27 ia any injury or other trau Irene Davis 4003 Ritchie Highway Baltimore, Maryland 21225 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBuriel 2 Cremation 3 Removel from Stete Glen Haven Memorial Park 8/12/99 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 one Fairt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lafture. And only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequ Examiner Sta a physician and s the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Box 68760 Physician/Medical Due to (or es e cons ice of): Mending USe 23b. Did tobacco use contribute to the cause of death? Pert If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. the signed by t 1 Dysa 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peed has 2 0 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: after death. Director: After this certific 25. Was case referred to medical examiner?

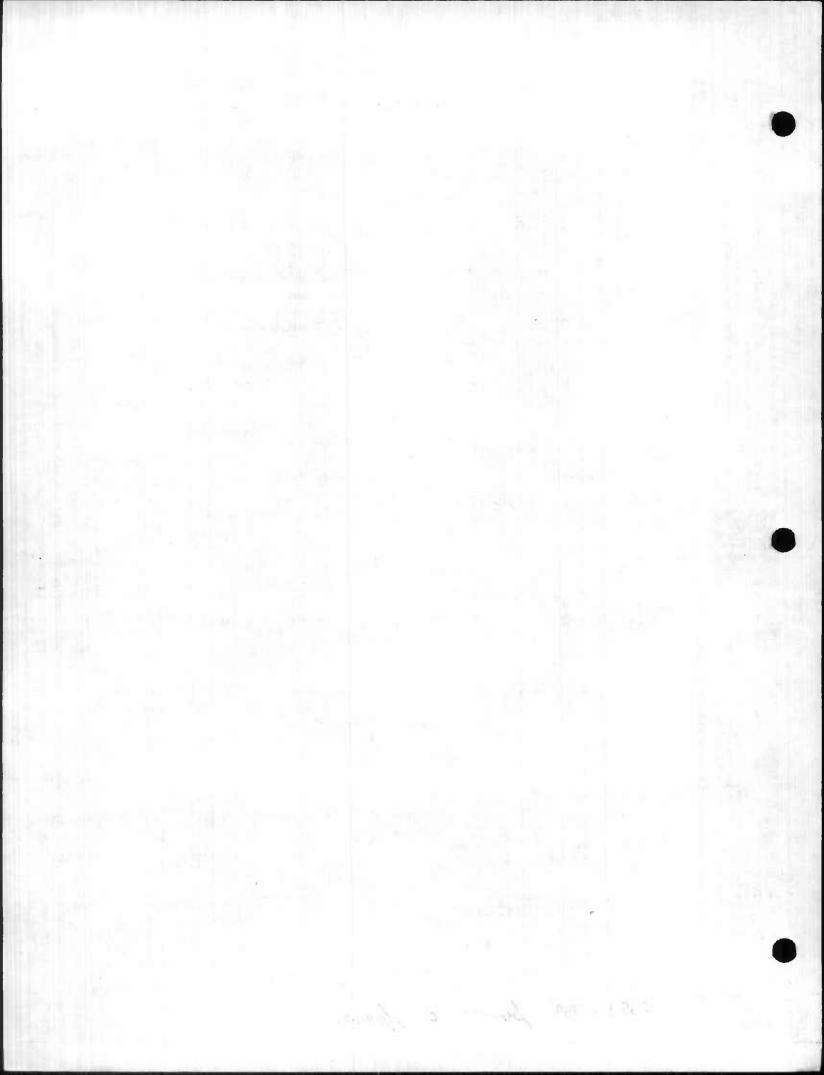
1 Yes 20 No 26. Place of Deeth (Check only one) 8 Other: 4 Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Neturel 5 Pending 1 Yes 2 No 2 ☐ Accident investigetion 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours aft Funeral Di detely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 3001 St. SAYATRI NIMM+GADDA Battimore Hanover Street Baltimor

State Registrar

DHMH 16 Ray 6/95

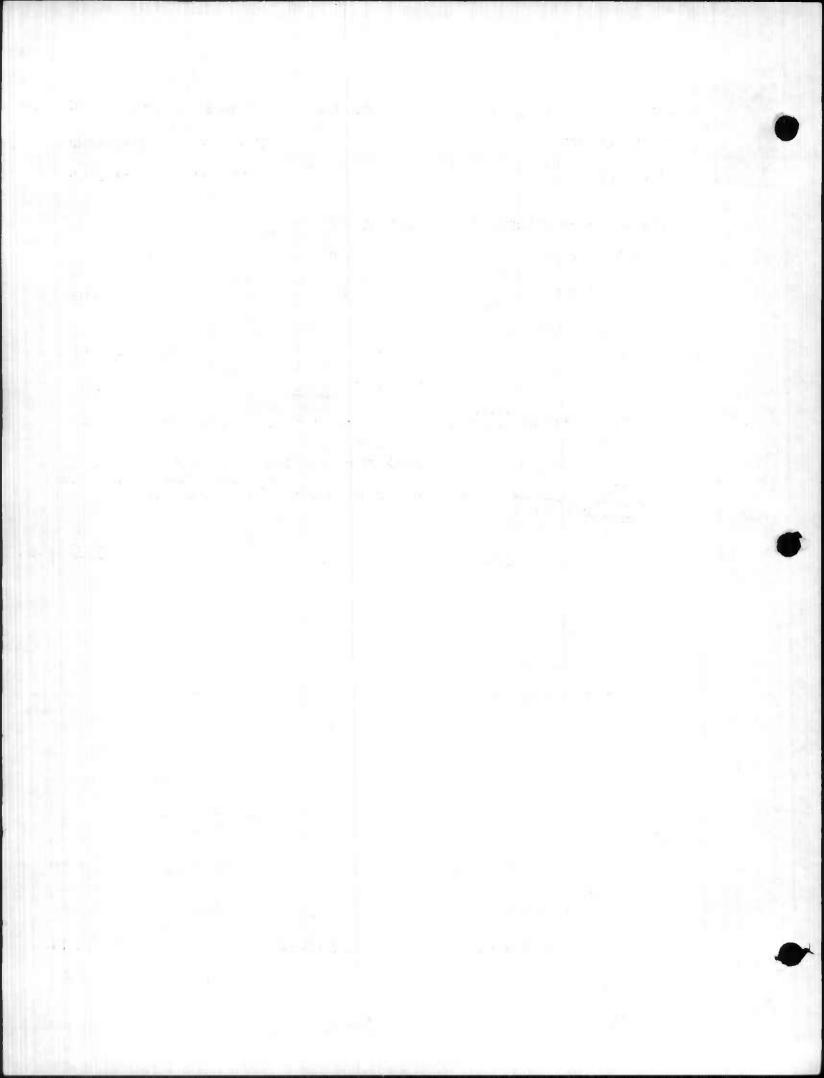
22. Registrer's Signature



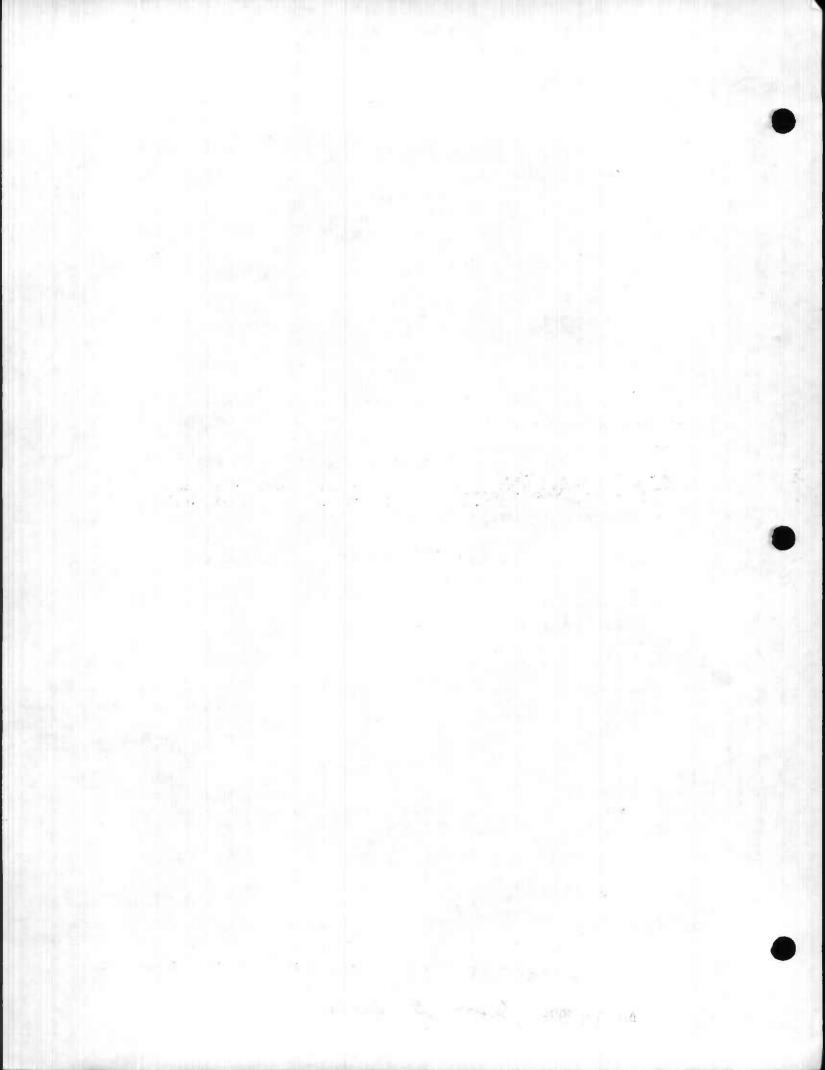
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State of Maryland / Department of Health and Mental Hygiene

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Division of	er der recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	iry - At home,	arm, stree	t, factory, office		28f. Location (St City or Town	reet end Numbe	or Aura	I Route Number,		
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	Michael			Ma	agar		M	aria			Z	affi	ris	
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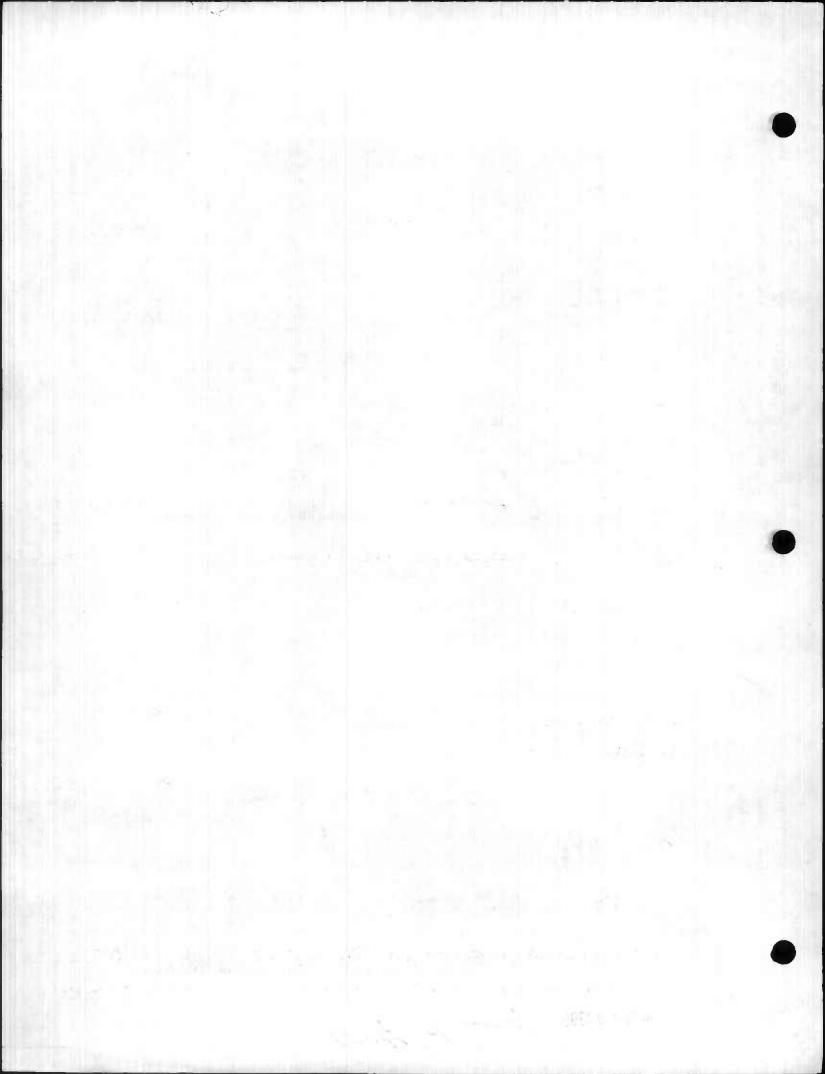
State of Maryland / Department of Health and Mental Hygiene 4

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Physician J FLORENCE GITTINGS 12 AUG 1999 8:45 am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 228 HOPKINS ROAD HAVRE DE GRACE HARFORD If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) JAN 28 193 Birthplace (State or Foreign Country)
 VIRGINIA **Funeral** Days Hours 1 ■ M 2 1 R 64 Months Yrs. 216-30-0181 Director Usuel Residence of Decedent the Maryland 10a. Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Directo MARYLAND HARFORD HAVRE DE GRACE 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen ot What Country? must be or 228 HOPKINS ROAD 21078 Funeral U.S.A. 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Reca - American Indien. Bieck, White, etc. filed within 72 hours after 1 Never Married 2XXMerried 21215-0020 8 1 ☐ Yes 2 XXVo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) during most of working Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) CERTIFIED NURSING ASSISTANT HEALTH 12th grade Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) . Pages I and 2 should be fin ment of Health and Mental H tant: if hem 27 is marked oth jury or other traumatic even Be THOMAS HOWZE BEATRICE HARRIS 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Arthur W. Gittings/Husband 228 Hopkins Rd., Havre de Grace, Maryland 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Fremetion 3 ☐ Removel from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 8-16-99 BALTIMORE, MARYLAND 21. Signeture of Funerel Service Licenses 22. Neme end Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA racera 321 S. Philadelphia Blvd, Aberdeen, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximata Intervel Between Onset and Deeth **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical Colon Carrier Hear Examiner Due to (or es e consequence of) Physician/Medical Examiner nding physician and use as the bunal-transit The law requires that the death certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Due to (or es e consequence of) P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2500 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes certificata 1 Yes of Vital Physician: 25. Wes case reterred to medical 26. Placa of Deeth (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 10 Certification: To After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deat 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Setural 2 Accident 5 Pending investigation after death. 1 Yes 2 No 28t. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier within 2 To the \$ 29b. Signeture 100 title of continue 29c. License number 29d. Dete signed (Month, Dey, Year) D005157 HINGHMO MD 30. Name and address of person who completed cause ot death (Item 23a) (Type, Print) 4920 CA 32. Registrar's Signeture MARES SUBELINE BAND MORE MARYUAND 21236 31. Date tiled (Month, Day, Year) State AUG 1 3 1999 Registrar

DHMH 16 Rev 6/95

B. Sparks ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 11:00 am Richard Green 11, 1999 August 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 6136 St. Regis Rd. Apt. F Baltimore 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Months Days Hours Min. Yrs. 216-42-8052 55 12/02/1943 Maryland Usuei Residenca of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6136 St. Regis Rd. Apt. F 21206 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Porter Airport 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Alice Johnson Harry Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Pieca of Disposition (Neme of cometery, crematory or other placa)

Apt. F, Baltimore, Maryland 21206

Date 20c. Location - City or Town, State Geraldine Green / Wife 20a. Method of Disposition
1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 8-17-99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetary 22. Name and Address of Facility The Derrick C. Jones Funeral Hm. 21. Signature of Funeral Servica Licensee 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Pert1. Enter the disease, or complications that award the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on all line. Approximate Interval Between Onset and Death 14 months Immediate Cause (Final Cancer disease or condition resulting in death) Unp Duo o (or as e consequenca of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 PYes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings svallable prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

end physician ed by the e signed by Records, peen : Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certified completely filled in by the funeral director, it

Certification:

Physician/Medical þ Completed Be 2

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Examiner

Physician

/Medical

Examiner

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permit. Peges 1 and 2 should be filed within 72 hours effer death with the Merylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or fierns 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

the buriel-tran

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Baltimore, Maryland 21215-0020

27. Manner of Death 1 BNaturai 2 Accident

29a, Certifier (Check only one)

3 Suicide 4 ☐ Homicide

29b. Signeture end title of pediliar

6 Could not be

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

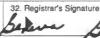
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brave, M.D Michael 31. Date filed (Month, Dey, Year)

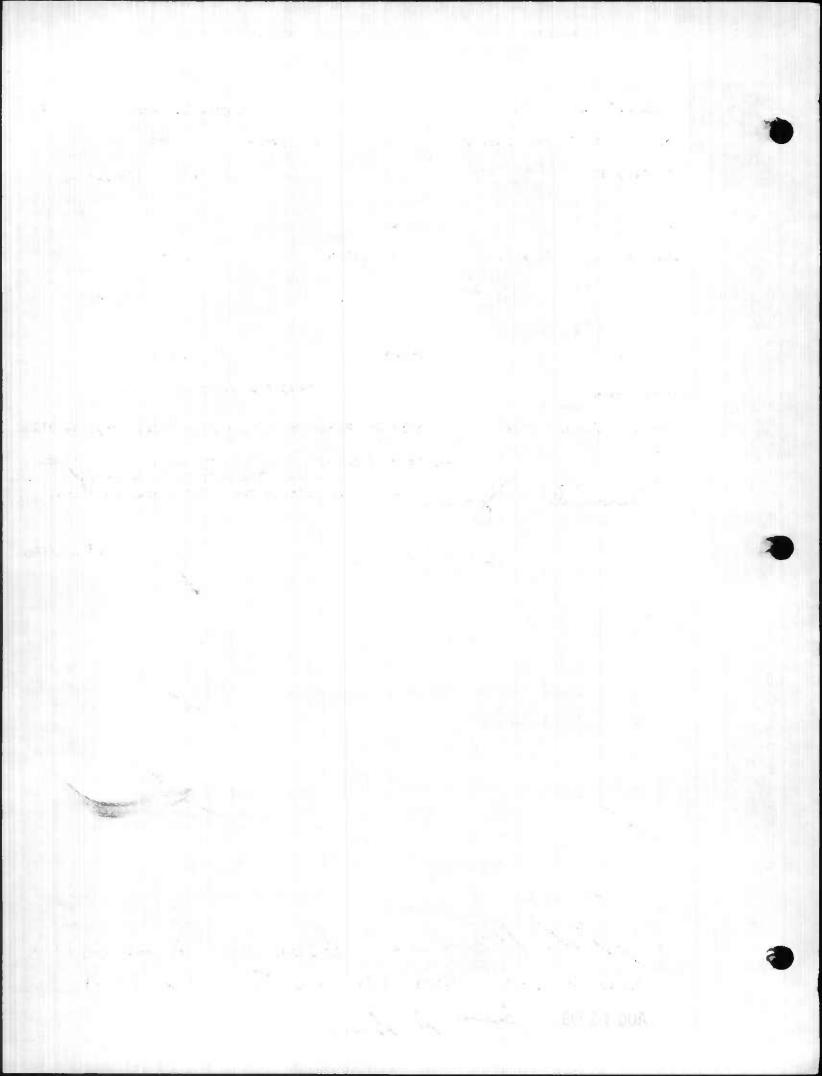
7600 Drive Osler

State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Sabeleter August 4b. City, Town, or Location of Death 02:45 4c. County of Death 4a Facility Name (If not institution, give street end number) paltimore MERCY Rd ISG T timure If Under 1 Year Birthplace (State or Foreign Country) 5. Social Sacurity Number Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 1□M 2XF Months Days Hours Min. Yrs 59 49 West Indies NA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 💢 No Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Patuxent 11379 Little 21044 West Indies 12. Was Decedant Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: 3 ☐ Widowed 4 ※ Divorced Black 15. Decedent's Education (Specify only highast grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry British Elementary/Secondary (0-12) College (1-4or 5+) Inventory Control Clerk Virgin, Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Louis Beavpierre Christine Taylor 19a. informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 11379 Little Patuxent Pkwy, Apt 835, Columbia Donald Fifield-Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition ₩ Burial 2 Cramation 3 Ramoval from Stata George's Anglican8/18/99 Tortola, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 I adu Wano 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximete Onset and Death Immediate Ceuse (Final disaese or condition resulting In death) Metastatic Monor Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

by

Completed

Funeral

Director

item 27 le marked other than "naturel", or itema 23a or 28a-f ehow other treumatic event, the Madical Examinet must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene. Important: if item 27 le marked other than "naturel", or item only injury or other treumatic event, the Medical Esemination.

altimore, Maryland 21215-0020

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g physician and as the burial-transit requires that the death certificate be executed 080 signed by certificate has funeral After s after death. To the Hospital within 24 hours a To the Funeral D

P.O. Box 68760 Division of Vital Records, or Attending Physician: Hospital

edical

State Registrar

5 Panding investigation

6 Could not be determined

29b. Signature and title of certifier

28a. Date of Injury (Month, Dey Year)

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

D40854

1 Yes 2 No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) laschers StPal brud 301

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21202

28d. Describe how injury occurred

31. Date filed (Month, Dey, Year) AUG 1 3 1999

27. Mapner of Death

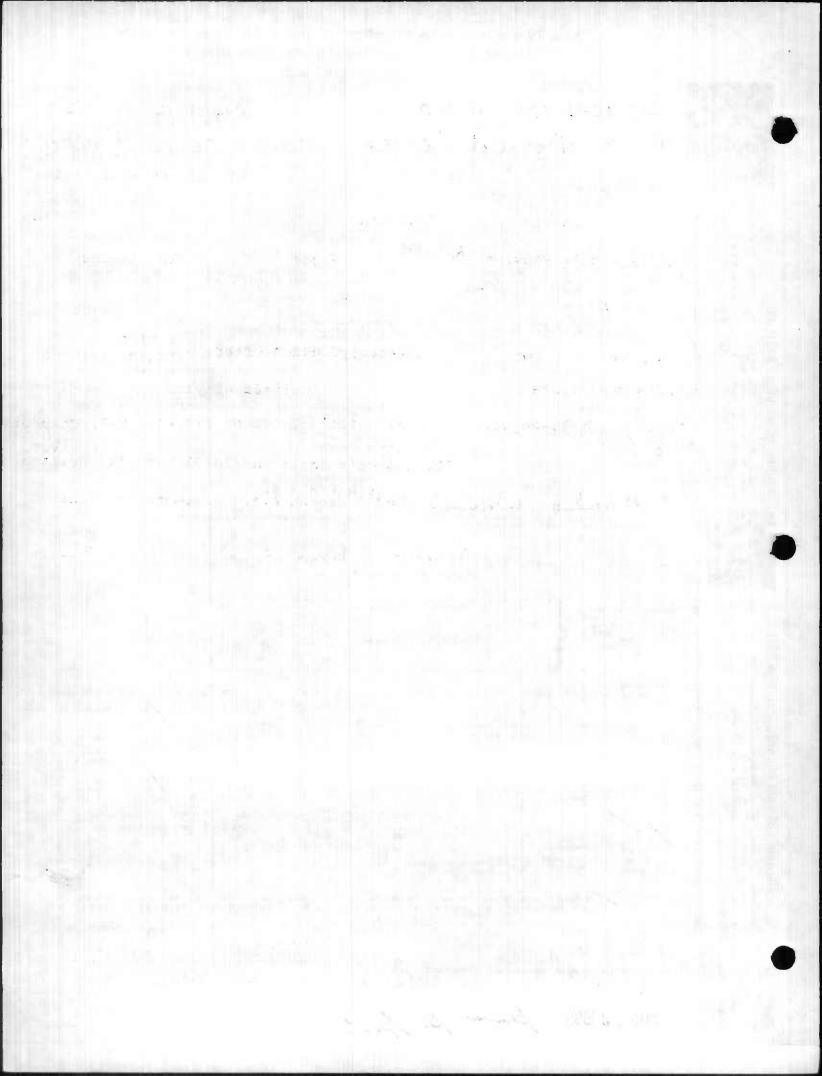
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2 Accident 3 Suicida

4 Homicide

29a. Certifier (Check only one)

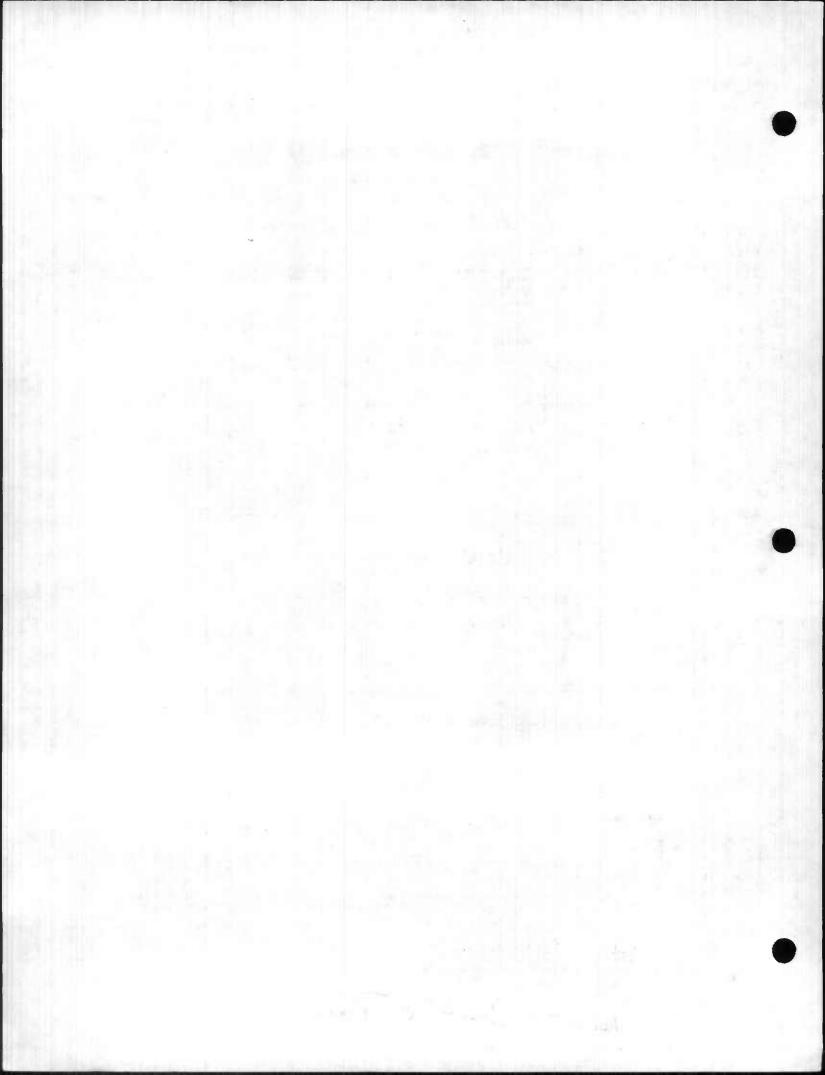
32. Registrar's Signature



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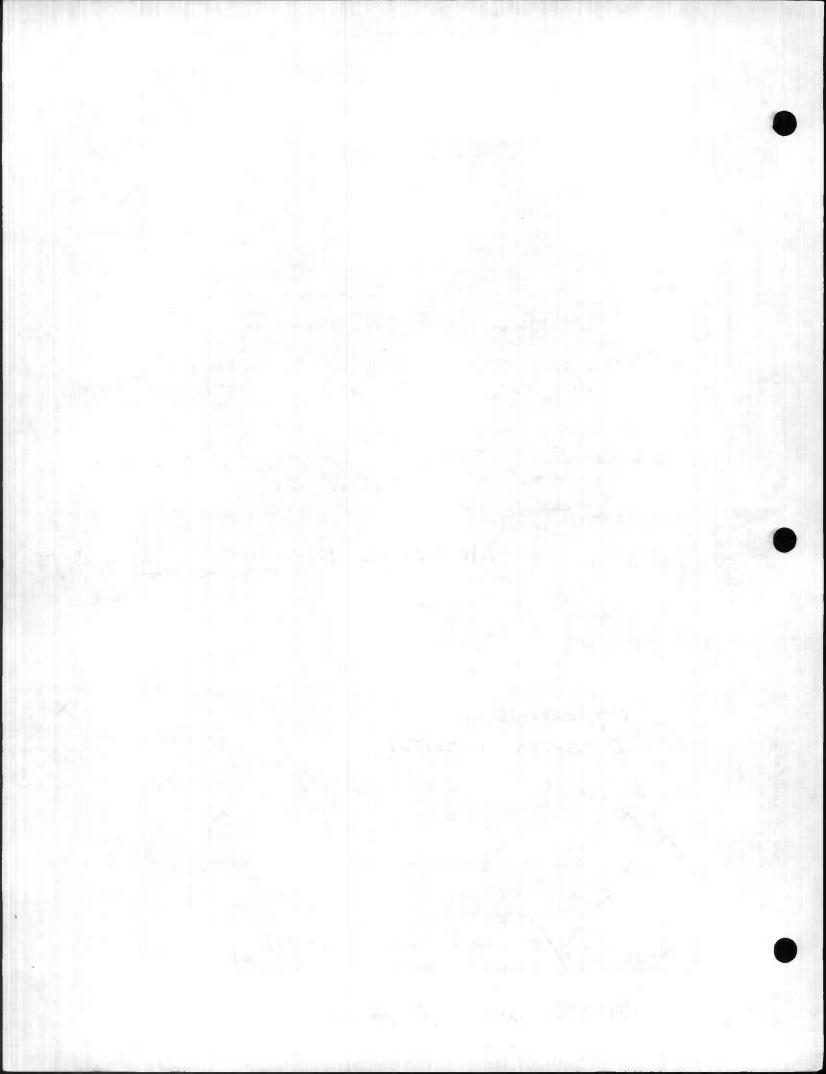
State of Maryland / Department of Health and Mental Hygiene

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of Vital Records, P.O. Box Physician: The law requires that the death cer- this certificate has been signed by the attendir- ral director, page 2 should be detached for use	Completed b	100								an autopsy ormed?	avai	e eutopsy tindings lable prior to
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/iSi	fice	3 Suicide	6 Could not be determined		jury - At home,	ferm, stree	et, tactory, office		28t. Location	Street and Numb	er or Rural	Route Number,
Diversity of Diversity	E T	4 Homicide	dotominos	building, e	ic. (Specify)				City or To	wn, State)		
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th Completely filled in by the funeral	ledicai C	29a. Certifier (Check only one)	Certifying Ph	ysician: To the best niner: On the basis of and manner si	of examinetion a	ge, deeth o and/or inve	occurred at the tostigation, in my	ime, date and pla opinion, deeth o	ace, end due to the courred at the time,	ceuse(s) and me date end place.	enner as sta and due to t	ted. he cause(s)
of this of the	Me	29b. Signature and	title of certifier				29c. Licen	se number		29d. Date signe	d (Month, D	ay, Year)
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B	11											
1	i	30. Name and address of person who sampleted cause of death (Item 23a) (Type, Print) Frances R. Jensen, MD Johns Hopkin; Hocpital, Baltimore, Maryland 31. Date tiled (Month, Day, Year) 32. Registrar's Signature B. Spacks										
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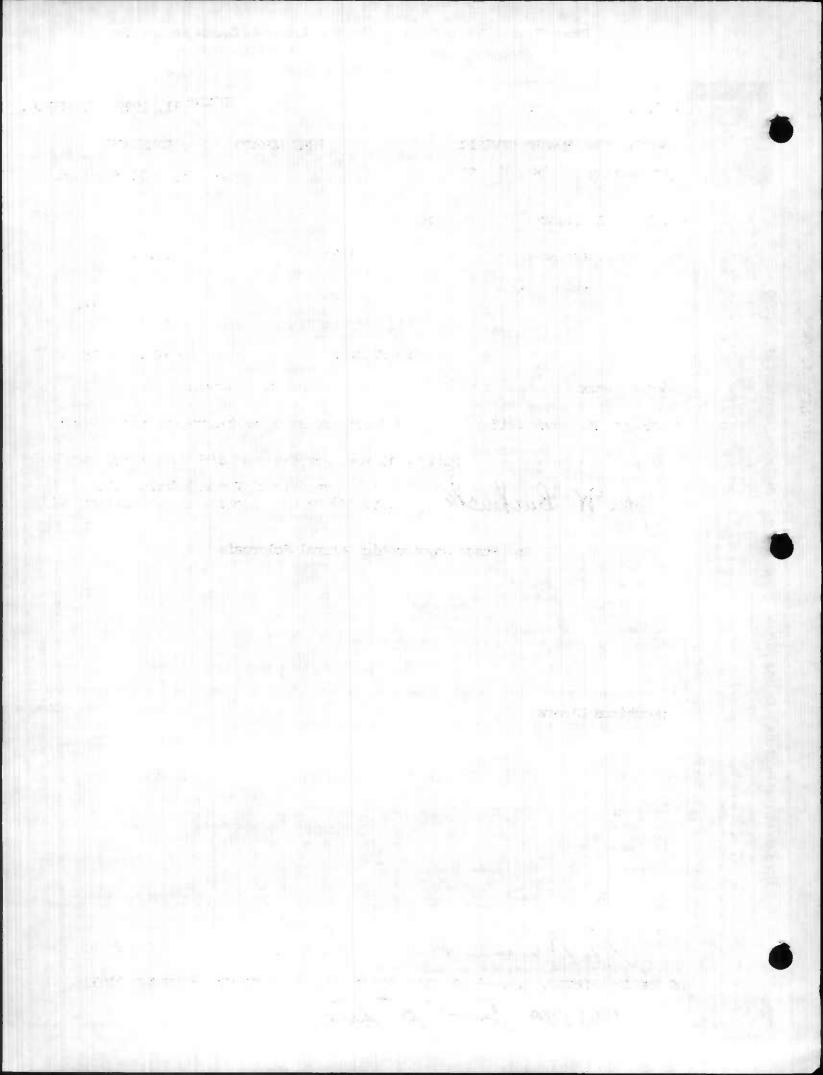
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	Eleanor Hedg	ges / wife			20 Margare	et Ave. I	Baltimore	Md. 21	221		
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Suce	21. Signature of Funeral Serv	/	0	11	22. Name and Addre	Funoral	Home of	Feeev			
9000	Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 23a. Parti. Enter the disease, or complications that caused the death. Dance enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart lailure. List only one sause on each line. Approximate totelvel Between Onset and Death										
an cal examiner	Immediate Cause (Final disease or condition resulting in death)	a	ME	TA STA			TIC		1	3 upos	
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с		to (or es a con							
Physician/Med											
900	Part II. Other significant con-	23b. Did 1	23b. Did tobacco use contribute to the ca								
by Phy	HYP	BETES	SCOM)			10	Yea 2□ No	3 Probably	Unknown	
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o Be	25. Was case referred to med axaminer?	Hospital:			Oth	100	eth (Check only o				
-	- LJ PROGRADIN	28a. D	I Inpatient late of Injury Month, Day Ye	2 ER/Outpo	e of 28c. Injur	4 LI Nursing		dence 6 Oth			
Certification:		uld not be ermined 28e. P	lace of Injury uilding, etc. (5	At home, farm Specify)	, street, fectory, office		28f. Location (S City or Tox	Street and Numb vn, Stata)	per or Rural Rout	e Number,	
edicai	29a. Certifier (Check only one) Certifier (Medical Certifier)	cal Examiner: Op ti	ne basis of axa	amination and/o	eath occurred at the tir r investigation, in my o	ne, date end plac opinion, death occ	e, and due to the surred at the time,	cause(s) and ma date and place,	anner as stated. and due to the c	ause(s)	
	29b. Signature and title of control 29c. License number 29d. Dete signed (Month, Day, Year)										
Competery filled in by the funeral director, page Medical Certification: To Be Com		you	na		0	18526		81	13/7	7	
W	30. Name and address of personal Naeem Gau				pe, Print)	altimo	ce Md.	21221	13/9	7	



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

			State of Maryl	and / D	epartment of lace of Certificate of	Health and M Death		giene 9 9	251	481
		1. Decedant's Nama (First, Middle, La	st)				2. Data of De		Yaer 3.	Time of Death
Physi Med/		William James N	Heck				AUGUS'	11, 19		0:45P.M.
Exam		4a Facility Nama (If not Institution, give	e street and number)			4b. City, Town, or Lo	ocation of Deat	4c. County	of Death	
		VAMHCS, FORT HOW				FORT HOWAI		BALTI	the state of the s	
Funera		5. Social Sacurity Number 8. 5	Sax 7. Aga (In)	yrs. last birt	hday) If Under 1 Yaar Months Days		8. Data of Bir (Month, De			(State or Foreign
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/land		10a. Stata 10b. County	100	City, Town	or Location				10d. lr	nsida City Limits
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ith the Marylan or 28a-f ehow	Directo	10e. Street and Number			10f. Zip Coda			10g. Citizan of V	Vhet Country?	
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	by F	1 ☐ Navar Marriad 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forcas? XXYas 2 No If Yes, Give Yaar or Datas:	orean	1□ Yas 200No	Specify:		Specify	White	
72 hours at		15. Decedant's E			Decedent's Usuel Occu	pation		16b. Kind of Bu		
20	Completed	(Specify only highest gra	ade completed)		(Give kind of work done life. DO NOT use retire	during most of work	ring			
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be filed within that Hygiene.	Be	17. Fathar's Name (First, Middle, Last)			18. Mothar's Nam			Θ)	
Mer Mer	2	Adolph Heck				Bertha	Marsha			
2 sho		19a. Informant's Name/Ralationship (Mailing Addrass (Stree					
s 1 and 2 sh f Health and from 27 ie m other traum		Charlotte M. He	ck (wife)		3 Hampshire Disposition (Name of	e Road, Ba	altimor Deta	e, Maryl 20c. Location -		
or of the		1 Xxurial 2 □ Cremation 3 □	Ramoval from Stata	cem eter	y, cremetory or other ple					
Dallumore, Ma pemit. Pages 1 and 2 st Department of Health and Important: If Item 27 ie n any injury or other traur		4 Donation 5 Other (Special		OTTA F	Hill Mem. G	14	8/16/99	Baltimo	re, Mai	rytand
Department of the second of th	OUCE	Carlo	0 0 6			uzdzinski	Funera	1 Hame,	P.A.	
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death cert death cert e attendin	Physician/M						not but			
the dy	ysi	Part II. Other significant conditions of		rasulting In	tha underlying causa g	ivan in Part I.				y 4 🖫 Jinknown
that thed be dete	by PI	Decubitus Ulcer	S					133 2LINO	3 Probability	y 4 Capitalowii
requires that the been signed by the should be detach.							24a. Was	an autopsy		autopsy findings bla prior to
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ing Ph ing Ph inneral	O.	27. Magnar of Deeth 1 DNeturel 5 □ Panding	28a. Data of Injury (Month, Day Yea	28b. T	ime of 28c. Injury Wo		28d. Describe	how injury occur	red	
r Attending ter death. rector: After by the fune	cat	2 Accident Investigation 3 Suicide 6 Could not be				Yas 2□No	29f Location	Street and Numb	nor or Pure! Po	uto Number
or All	Certification:	4 ☐ Homicida datarmined	building, atc. (Sp	ecify)	rm, streat, factory, office		City or To	wn, State)	er or ridrarrio	die Mulliper,
pltai ours filled		29a. Cartifiar 1N Certifying Pt	nysician: To the best of my	knowledga	daath occurred at tha t	tima, data and place.	and dua to the	causa(s) and ma	annar as stated	d.
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		ninar: On the basis of axan and mannar stated.							
To the Within To the	Me	29b. Signature and title a pertifier	1		29c. Lican	nse number		29d. Date signe		, Year)
1		1 /H/	Usm'ce	M.E	0 0 4	17804		8/12	199.	
"PKI		30. Name and address of person who		(Item 23e) (
11		DR ANDREW MROWIEC	, M.D9600	NORTH	POINT ROAL	D, FORT HO	DWARD, I	ARYLAND	21052	
	tate	31. Data filed (Month, Day, Yéar)	32: Registrar's S	ignature	4	,				
Regis	strar	AUG 1 3 19	99 -	1	. spork	~				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Dete of Deeth 1840 Vivian Helene Hardie 4b. City, Town, or Location of Death 1999 0 4c. County of Deeth 4a Fecitity Neme (If not institution, give street and number) Cherry LAME Laure Hours Min. 8. Date of Birth (Month, Day, May 3, 5. Social Security Number If Under 1 Yeer Birthplace (State or Foreign Country)
 I OWa 7. Age (In yrs. last birthday) Months Days 1 M 2 TyF 93 Yrs. 549-62-0091 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Prince George Maryland Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9266 Cherry Lane #53 20708 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Spacify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementery/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumema) Frank Tanner Mc Connell Aimee Mc Dowell 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Sandra Brown/Daughter 409 Fourth Street Laurel, Maryland 20a. Method of Disposition 20b. Pleca of Disposition (Nama of camatary, crematory or othar placa) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 8/13 Balt. Wash. Crematory Laurel, Maryland Other (Specify) al Envice Lice 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Deeth Cardio unscular Disease Immediate Cause (Finel disease or condition resulting in death) Sequentially tist conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or thjury that Initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 3 Probably 4 donknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1-ENaturel 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and manner as staled.

Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner stated.

Records, P.O. Box 68760, Division of Vital

i or Attend after death Director: To the Hospital or Atte within 24 hours after de To the Funerat Directo completely filled in by the

Physician

/Medical

Examiner

Director

Funeral

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Funeral

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7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

other 1

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Physician /Medical

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Certification: To

Medical

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(Check only one)

29b. Signeture and title of certifier

29a. Certifier

Pages 1 and 2 should be filed within 72 hours after death and of Health and Mental Hygiene.

Itt: If them 27 is marked other than "nature", or items 23.

Baltimore, Maryland 21215-0020

the Maryland

State Registrar

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 31. Date filed (Month, Day, Yaar)

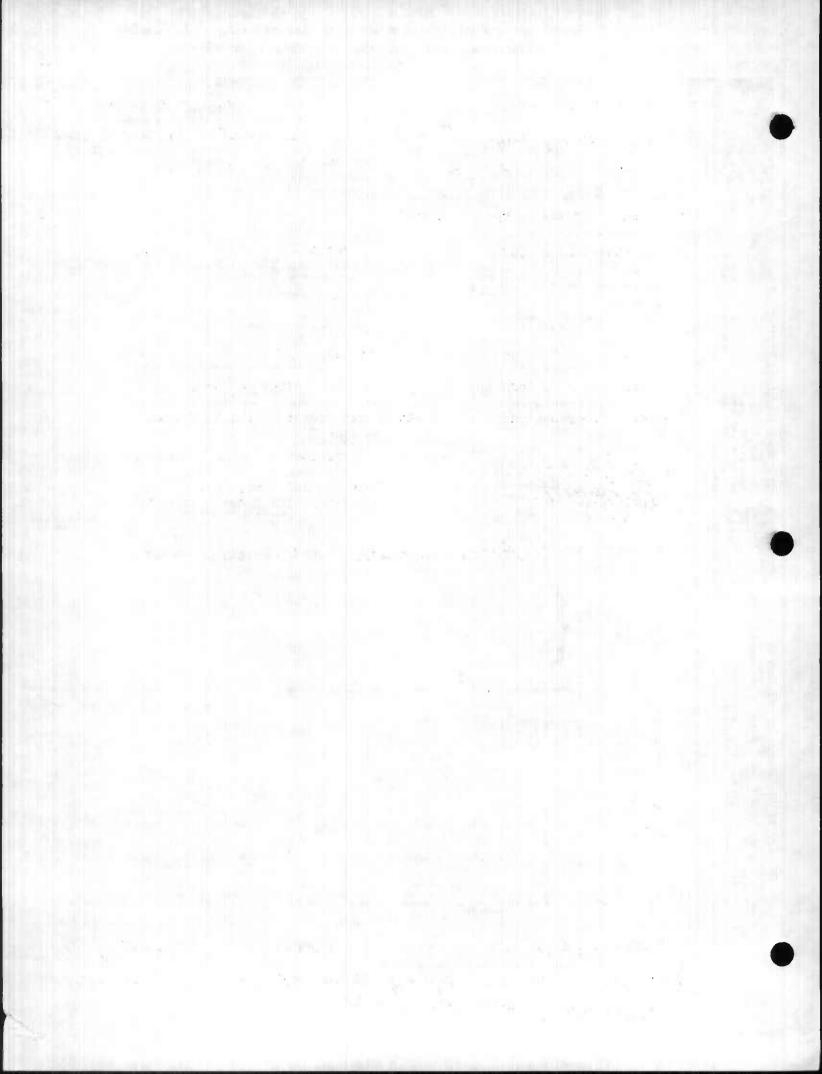
AUG 1 3 1999

3001 Hospital Drive, Cheverly, Mary land 32. Registrar a Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death #23 PART II PER MD G775 9-8-99 WR. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month ROSALIE Т. HARTHAUSEN 7:30 P.H 4e. Fecllity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GENESIS ELDERCARE SEVERNA PARK SEVERNA PARK ANNE ARUNDEL CO. If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (in yrs. last birthday) 8. Dete of Birth (Month, Dey, June 30 Birthplece (State or Foreign Country) Deys Min. Months Hours 1□M 2√2 F 214-50-2049 Yrs. 1912 Maryland Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. n/a Baltimore No Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21230 1505 Clarkson Street USA Wes Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 20 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Busineas/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife Home Owner 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Thomas LaMar Amelia Dash 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Rosalie A. Sparra (Daughter) 1505 Clarkson Street, Baltimore, Md. 21230 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park 8/14/99 Glen Burnie, Md. 21. Signeture & Funeral Service Licenses 22. Name and Address of Fecility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave., Baltimore, Md. 21230 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final PNEUMONIA 2 DAYC diseese or condition resulting In deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequenca of): Due to (or es e consequence of) 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown DISEASE EMPHYSEMA 24b. Were eutopsy findings evellable prior to completion of cause of death? 24e. Wes en eutopsy performed? DIABETER 2DNo 1 Yes 2 No 1 Yes 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred

The law requires that the death certificate be executed Bud Division of Vital Records, P.O. Box 68760. attending physician signed by I or Attending Physician: this After t death. after death

Physician/Medicai

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Completed

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Medical Certification: To

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within 24 hours a To the Funeral D completely filled the Hospitai

Physician

/Medical

Examiner

Funeral

Director

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. Pages 1 and 2 should be file iment of Health and Mantal Hy lant: If Item 27 is marked oth jury or other traumatic svent

Department of fmportant: If any injury or

Physician /Medicai

Examiner

traumatic svent, the Medical

Director

Completed by Funeral

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death with the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. IS CHEMIC HEART 25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. 29e. Certifier 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and dua to the cause(s) end menner stated. (Check only one)

Ulledi 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

29c. License number 29d. Dete signed (Month, Dey, Year)

21776

AUGUST 11

P. MUNDRA NO 3001

S HANOVER ST BARIMORE ZEE

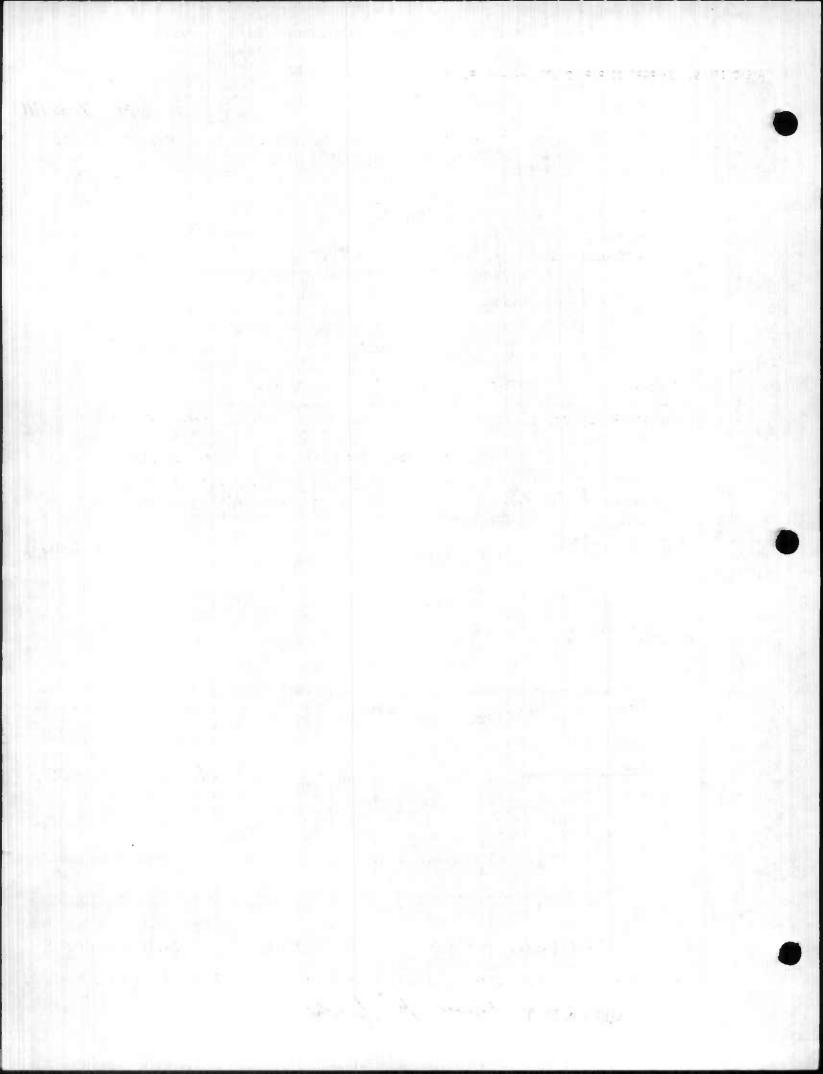
Registrar

31. Dete filed (Month, Dey, Year) AUG 13 7999

29b. Signeture end title of certifier



32. Registrer's Signeture

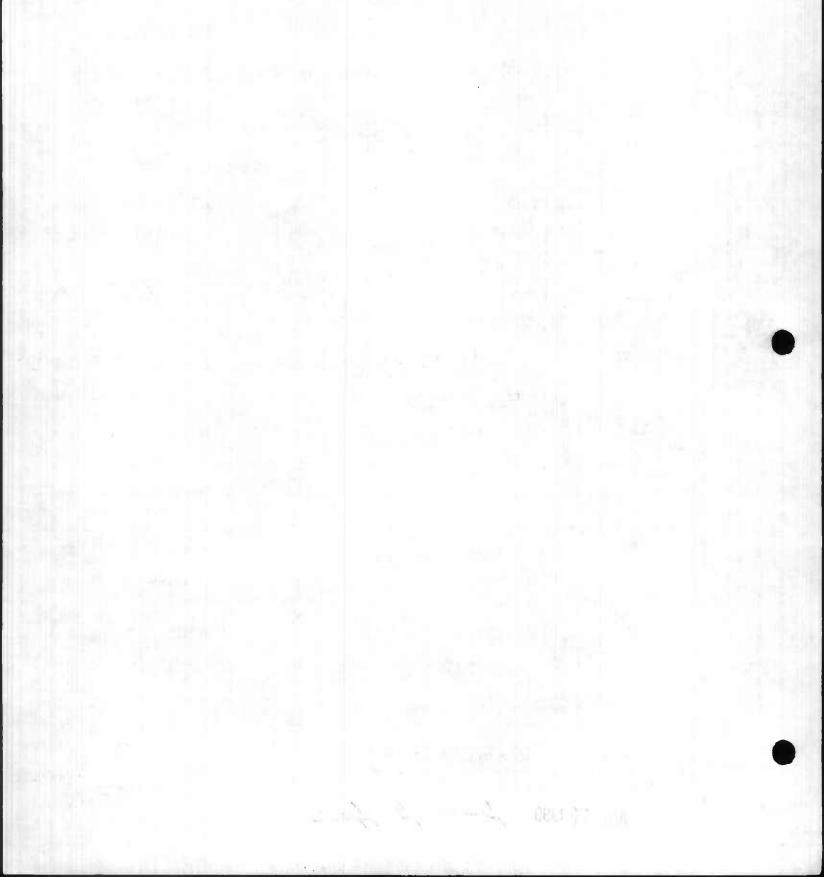


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0

Department Dep				,	Cer	tificate o	f Death		Reg. No.	20404
Narry Alice Haer AUC 10, 1999 12:10p			1. Decedent's Neme (First, Middle, Last)					2. Date of De	ath	
45 S. L. Agende Nurs Sing & Rehalb. Center 5. S. L. Agende Nurs Sing & Rehalb. Center 5. S. L. Agende Nurs Sing & Rehalb. Center 5. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 2. South Scientific Number 3. South S			Mary Ali	ce Haer						
S. Social South Number 2.16 - 0.11 - 3.03 o	A10		4a Facility Neme (If not institution, give s	treet and number)			4b. City, Town, or			
Discolor Discolor	87		St. Agnes Nursi	ng & Rehab.	Cent	er			y Hov	vard
The state of the state and Number Total State Total County			216-01-3030		"			/Month De	r. Year) 2, 1914	9. Birthplace (State or Foreign Country) Illinois
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Elementary Secondary (0-12) College (1-4or 5-) Clerical Railroad	020 ours effer de nal', or frama	by Fune	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give				Specify Yes or No- rto Rican, etc.)		White, etc.
College (1-4cr 5-4) College (1-4cr 5-4)	5-0 72 h	peta	15. Decedent's Educ	ation completed)	16a. Deced	lent's Usual Occ	upation ne during most of wo	orkina	16b. Kind of Busi	iness/industry
17. Father's Names (First, Middles, Last) Lee Anderson Belle Moyer	121 lithin	Jqr.			tife. L	OO NOT use reti	red)			
Lee Anderson Decided Part Chilary Part Part Chilary Part Part Part Chilary Part		S	1.2		<u>C1</u> e	erical	T 40 44-4-1-1-1-1	45° 14°-14°-		
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Butial 2 Commence of Jerman Commence Secretary	Heal Heal			20b. Pl	lace of Dispos	SDICE sition (Name of	wind Ct	Dete COLU	mbia, N	1D 21 () 45 ity or Town, Steta
299 Frederick Rd. Baltimore, MD 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate training Between Onset and Death Physician Ph			4 Donetlon 5 Other (Specify)		ro Cre	ematory,	Inc. 08/	11/99	Baltimo	ore, MD
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24a. Wes en eutopsy performed? 24a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 20 No 1 Yes 2 No North, Day Year 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No North, Day Year 1 Yes 2 No North, Day Year 1 Yes 2 No 1 Yes 2 No North, Day Year 1 Yes 2 No North, Day Year 1 Yes 2 No 1 Yes 2 No North, Day Year 1 Yes North, Day Year	0 9 4	ysic	Part II. Other algnificant conditions cont	ributing to death but not resu	ilting in the un	derlying cause	given in Pert I.	23b. Dld 1	obacco una cont	ributa to the cause of death?
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25. Wes case referred to medical axeminer? Yes 2 No	9 w w									aveilable prior to completion of cause
25. Wes case referred to medical axeminer? Continue The I	E O						101	res 20 No	1 ☐ Yes 2 ☐ No	
The control of the course of	/ita	Be					26. Plece of De	eth (Check only o	ne)	
Nature 1 Nature 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 Pending invest	hysic ce ligits ce	2		spitel: 1 Inpatient 2 1	ER/Outpatien	3□ DOA	Other: 4 Nursing I	Home 5 Resid	dence 6 □Other	(Specify)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)		ii o	-1	28a. Dete of trijury (Month, Day Year)		W	ury at ork?	28d. Describe I	now injury occurre	d
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	or Attanding the deep deep deep deep deep deep deep de	ertificati	2 Accident Investigation 3 Suicide 6 Could not be	28e. Plece of Injury - At ho building, etc. (Specify	me, ferm, stre		1000			or Rural Route Number,
	Hospitu 24 hours Funeral	edical 0	(Check only 2 Medical Examine	er: On the basis of examineti	vledge, death ion and/or inv	occurred et the estigation, in my	time, date and place opinion, deeth occ	e, and due to the urred at the time,	cause(s) and men date end place, an	ner as stated. Indicate the cause(s)
and manner steted. 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)	rithin Fo th	M	29b. Signeture and title of certifier			29c. Lice	nse number		29d. Dete signed	(Month, Day, Year)
Patra Cham Offs MD D47563 8/11/99			Palara (Dram Orli	SS M	D D4	7563		8/11	99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Chambliss MD 2 Knoll North Dr Columbia MD 2100				1 1	-	Print) 2 Kn	all Nov-	th Dr	Colum	whia MD 2104
State 31. Dete filed (Month, Day, Year) ALIC 18 1999 32. Refistrer's Signature		State	31. Dete filed (Month, Day, Year)	32. Redistrer's Signat						

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #24a PER MD G774 8/13/99 AH 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Bertha 6:30 PM July /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Baltimore If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 X F Yrs. 85 Director 579-20-1753 Nov. 1, 1913 W. Va. Usual Residence of Decedent with the Meryland 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or Name 23a or 28a-f ahor the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 Wentworth Road 21234 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, Whita, atc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yas, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2N No Specify: Specify: White à 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Cook Food Service other peimit. Pages 1 and 2 should be filed. Department of Health and Mentel Hyg Important: If Item 27 is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Annie Clagg 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Joseph B Van Sant State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201

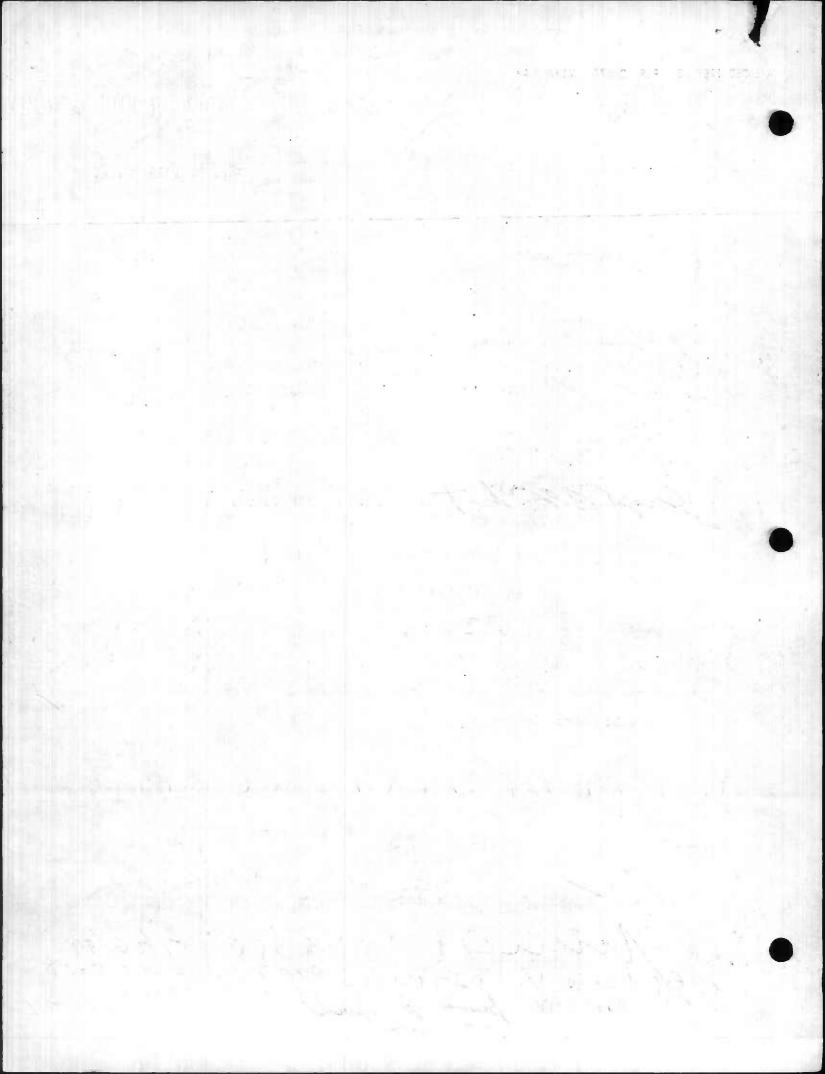
23a Part Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician Immediete Cause (Finel monard disease or condition resulting in death) Examiner Examiner reati physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a conseque P.O. Box 68760 Physician/Medical Due to (or as a consequence of) for use as 88 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No been signed tahould be det Ischemic Heart Disease py 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? pege 2 1 ☐ Yes 2 ☑ No 1 □ Yes 2 □ No certificate Division of Vital 25. Was case referred to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d, Describe how injury occurred Certification: After 5 Pending NA 1. Netural e Hospital or Attending 24 hours after deeth. e Funeral Director: After NA 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Placa of Injury - At home, term, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and placa, and due to the cause(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifie 29c. License number 29d. Date sigged (Month, Day, Year) 2 ddress of person who completed cause of death (Item 23a) (Type, Print) 3 121 CTO

DHMH 16 Rav 6/95

State

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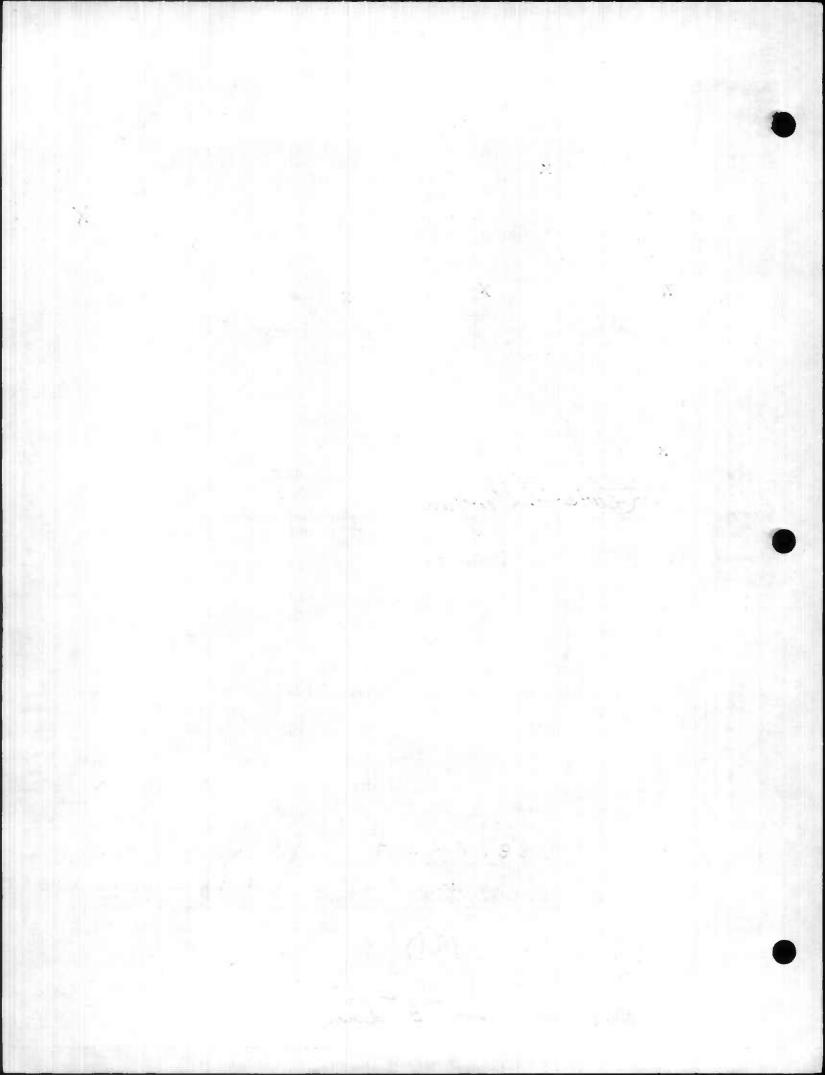


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	sician edical		SISTOPHER HO				2. Date of De Month August	Day 19	3. Time of Death 10:03 A.M.			
Exa	miner	4a Facility Name (If not institution, giva Under I-695 near	4b. City, Town, or L Dundalk				·a					
Fune Direct		5. Social Security Number 6. Se 2 1 6 88 3641		last birthday)	If Under 1 Year Months Days	If Undar 24 Hrs.	8. Data of Bird Month Da DECII,	h		ace (Stata or Foreign		
with the Maryland a or 28a-f show the notified at	nd at	Usual Rasidence of Decedent 10a. Stata 10b. County MD . N/A		y, Town or Lo					10	Dd. Insida City Limits 1 Yes 2□ No		
eath with the Maryla ns 23a or 28a-f sho must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizan of \	What Count	ry?		
€ 23 €	alD	1604 N. FULTO	7		U.S	. OF	Α.					
The red	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U; Armed Forces? 1 ☐ Yes 2 X No If Yas, Giver Year or Dates:		Vas Decedent of Yes, specify Cut	Hispanic Origin? (Sp ban, Mexican, Puarto Specify:	ecify Yas or No Rican, atc.)	1	e - America ck, Whita, a	itc.		
Maryland 21215-0020 d.2 should be filed within 72 hours at this and Mental Hygiene. 7 te marked other than "natural", or trearmelic event, the Medical Exam.		15. Decedent's Edu (Specify only highest grad	pation	rina	16b. Kind of B	usinass/Ind	ustry					
villan ene. Iban	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) JNKNOWN			during most of worked) CLERK		DIIDI T	CUIN	G COMPANY		
d 2		17. Father's Nama (First, Middla, Last)	INKNOWN	SHIP	Pund	18. Mothar's Nam	a (First, Middle,			G COMPANI		
/lan	To Be	FRED C. HOWELL	J			ANNIE	E. TIS	DALE				
Aary and N	1.5	19a. Informant's Name/Ralationship (T)	pe, Print)	19b. Mailin	g Addrass (Stree	at and Number or Ru	ral Routa Numbe	er, City or Town,	Stata, Zip	Code)		
		DENISE HOWELL (RTH ROAD		O., MD.	212	18		
Baltimore,		20a. Mathod of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F	lamous from State	ematary, cren	sition (Nama of natory or other pla N CEME	TEDV 8/	Data 20c. Location - City or Town, Stata BALTIMORE, MAR					
Itin		4 Donation 5 Other (Specify)					11/99					
B Page	8000	21. Signature of Fuperat Sorvice Lieuwa L. W. 1.8 T. GWYN N ^{22.} Nama and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-63 4517 PARK HEIGHTS AVE. BALTOMD.										
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the death	n. Do not ente	4517 or the mode of dy	PARK HEI	GHTS A	VE BA		. MD .		
Physicia /Medic Examin	al er	Immediata Causa (Finat disease or condition rasulting in death)	Drownin							tritarvat Batween Onset and Death		
D	iner i		0									
8760, cata be executed physician and the burial-transit	cai Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or	r as a conseq	uence of):							
Geath certificate be extending physician of for use as the buria	(D)	that initiated events resulting in death) Last										
death death of for	Sic.	Part II. Other significant conditions cor	stributing to death but not resu	ulting in the un	derlying causa g	iven in Part I.	23b. Did	lobacco uee co	ntribute to	the cause of death?		
P.O hat the detached by the	by Physician/M						23b. Did tobecco use contribute to th					
aw raquir	Completed							an autopsy med?	ava	ra autopsy findings illabla prior to npletion of cause leath?		
- F # Z	Co						1)×1	ras 2□No	100	Yas 2□ No		
Of Vital I Physician: Th this certificate	o Be	25. Was case refarred to medical axaminer?	lospital:		_ [0	26. Place of Dea						
Phy Phy	-	1⊠ Yas 2□ No 27. Manner of Death	28a. Data of Injury	ER/Outpatien 28b. Tima of	28c Inju	ary at		dence 6 DOth		at scene		
Division or Attending I after death. Director: After Jin by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be detarmined	(Month, Day Year) 8. 8. 99 Fund 28e. Place of Injury - At ho building, etc. (Specify	Injury 1003 ma, farm, stre	AM 10	Yas 2 No	28t. Location (S City or Tox	Street and Numb	that Sper or Rural	ank in Bay		
DIV To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by	edicai Cer	29a. Certifier 1 Certifying Physic (Check only one) 27 Medicat Examination	Bay - Pato sician: To the best of my knowner: On the basis of axaminat	PSCO R	occurred at tha t	ima, data and place, opinion, daath occur	Key Bridge	causa(s) and mi	25 Durannar as sta	Malk, MD nted. tha causa(s)		
To the Within 2 To the	Med	29b. Signature and Alle of certifier	and manner stated.	1		se number		29d. Dala signe				
- 3 - 8		1 Jew	teiner, M	1-D.		O.C.M.E.		August (
		30. Name and address of person who co	. Pestour	er 1		Street, B	altimor	e, Mary	land 2	21201		
	State	31. Date Hind (Month, Day, Year)	32: Registrar's Signal	mre /		,						

DHMH 16 Rev 6/95

State Registrar

AUG 1 3 1999



ASPIRATION

Due to (or as a consequence of):

Due to (or es a consequence of)

Physician /Medical Examine physician and the burial-transit that the death certificate be executed

signed by the a

certificate

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After or Attanding

death.

To the Hospital or Attandit within 24 hours after death. To the Funeral Director: All completely filled in by the fu

Box 68760

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Records,

Division of Vital

29a. Certifier

(Check only one)

disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide 4 Homicide

Physician/Medical P Completed Be Medical Certification: To

24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 TYes 2 TNo

PNEUMONIA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPITHEDRIVE, GLENBURNEE

29c. License number 4

29d. Date signed (Month, Day, Year) AUGUST

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No

2-28 Am

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

1999

Korea

Korean

21075 Approximete Intervat Between Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No

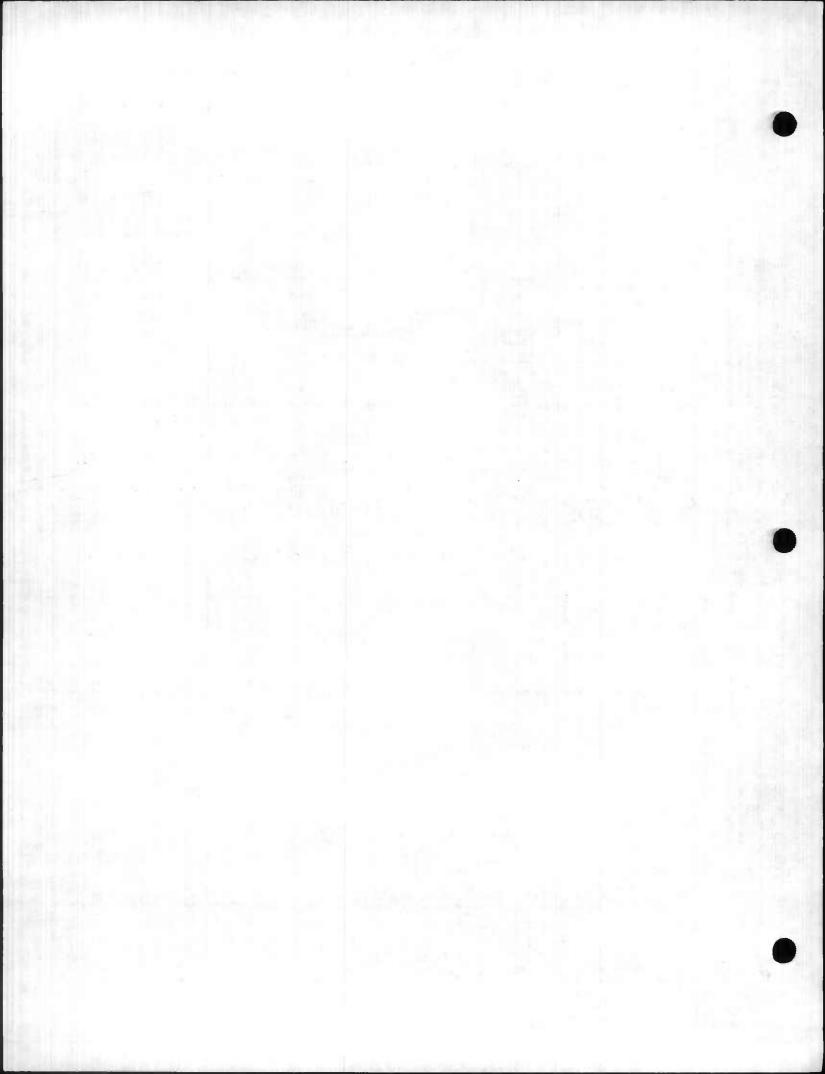
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31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar DHMH 16 Rev 6/95

State



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12,199910:30AM Month Augus-Lona Melinda Kimble 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Cosedale Baltimore If Under 24 Hrs. Hours Min. (Month, Dey, Year) August 13, 1905 West Virginia Franklin Square Center Hospital If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days 1 M 20% 217-22-0022 Yrs. 93 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Transverse 21220 U.S.A. Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 200 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes No Specify: Specify: White ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) House Wife 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) William F. Spitzer Nellie Smith 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 9726 Conmar Road, Baltimore, Maryland 21220 Wayne E. Kimble (son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition 1 XXurial 2 ☐ Cremation 3 ☐ Removei from Stete Holly Hill Memorial Gar. 8/16/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Bruzdzinski Funeral Home, P.A. 21. Signay re of funeral Service Licenses 23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart feilure. List only one cause on each line. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximete Intervel Between Onset end Death Immediate Ceuse (Finel Accident Cerebrovascular disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No t ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Important if Iham 27 is any injury or other tre-

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Physician

/Medical

Examiner

Funeral

Director

or 28s-f show

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Baltimore,

Box 68760.

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Funera

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Completed

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16

Examiner physician and s the burial-transit The law requires that the death certificate be executed Physician/Medical Completed page 2 certificate Be

Certification: To

 Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificalety filled in by the funeral director; p. To the H within 24 To the Fi complete

Medical

State Registrar

anne

5 Pending

investigation 6 Could not be determined

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) August 12, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

30. Name and address of persony o completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, MD 21237 O.Lamora larc

31. Date filed (Month, Dey, Year)

25. Was case referred to medical

1 Yes 2 No

axaminer?

27. Mannar of Death

1 Natural

2 Accident

3 Suicide

29e. Certifier

4 Homiclde

(Check only one)

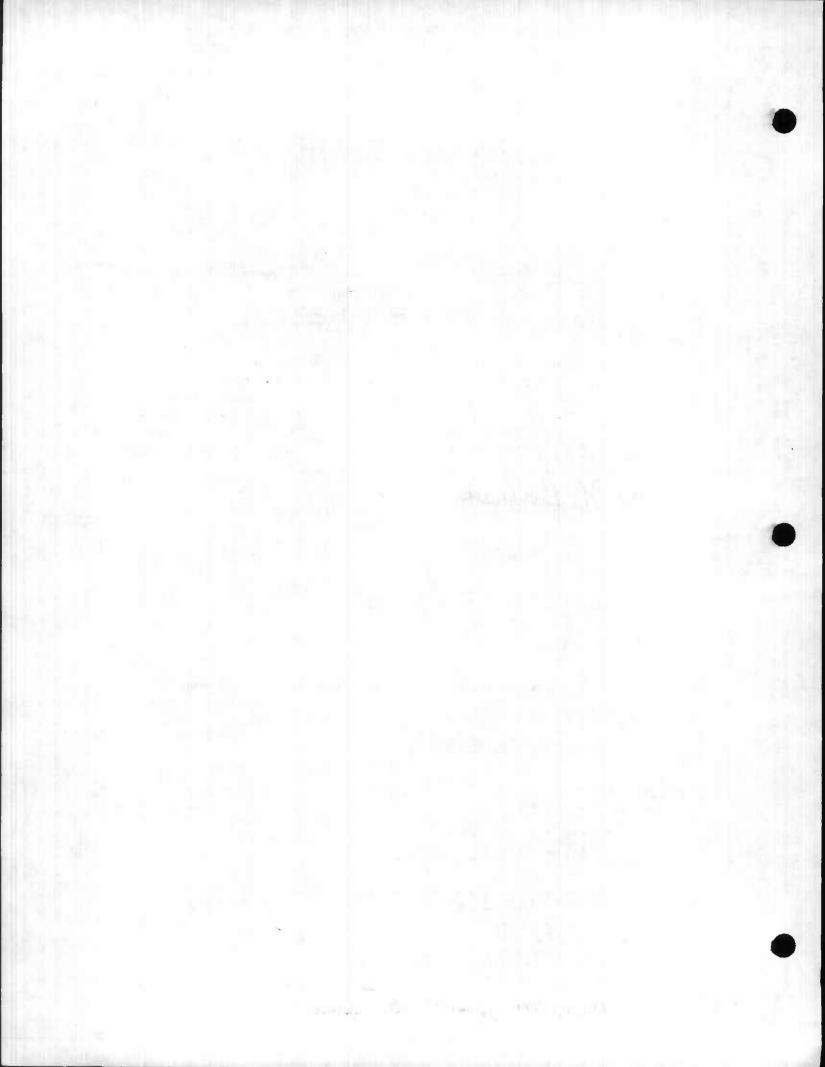
AUG 1 3 1999

32. Registrer's Signeture

2 ER/Outpatient 3 DOA

28b. Tima of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3 Time of Death Month Physician August Carolyn Kuscharsev 11 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Aanes Healthcare Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 96 Yrs. Maryland 705-10-5045 March 15, 1903 Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I is marked other than "natural", or items 23a or treumatic event, the Maulcal Examinar must be a 715 Maiden Choice Lane CC402 21228 United States should be filed within 72 hours after death and Mental Hygiene. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 Ø No It Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: by White 3 N Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary Legal 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) end Mental I Henry John Langenfelder Anna Langhirt 19a. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pagas 1 and 2 sh Department of Health end Important: If Item 27 is m any Injury or other treum pncs. Madelyn L. Langenfelder / Sister 715 Maiden Choice Lane #CC402 Catonsville, MD 21228 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8/14/99 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility Michael E. Canapp 5305 Harford Road MICR LEONARD J. RUCK, INC. Baltimore, 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disaase or condition resulting in death) myscordial infarction are how Examiner Due to (or as a consequence ot) Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown by 24b. Were eutopsy tindings available prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Completed certificate has b 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Netural 1 Tyes 2 No To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: All completely filled in by the fu Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 4 ☐ Homicide 29e. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)

arolan

The law requires that the death certificete be executed

or Attending Physician:

with the Maryland

Baltimore, Maryland 21215-0020

Registrar

31. Date tiled (Month, Day, Yeer)

Robert

AUG 1 3 1999

Greenhald 900 Can Avene: Baltman, Md. 21229 32. pogistrar's Signature

MD.

MO

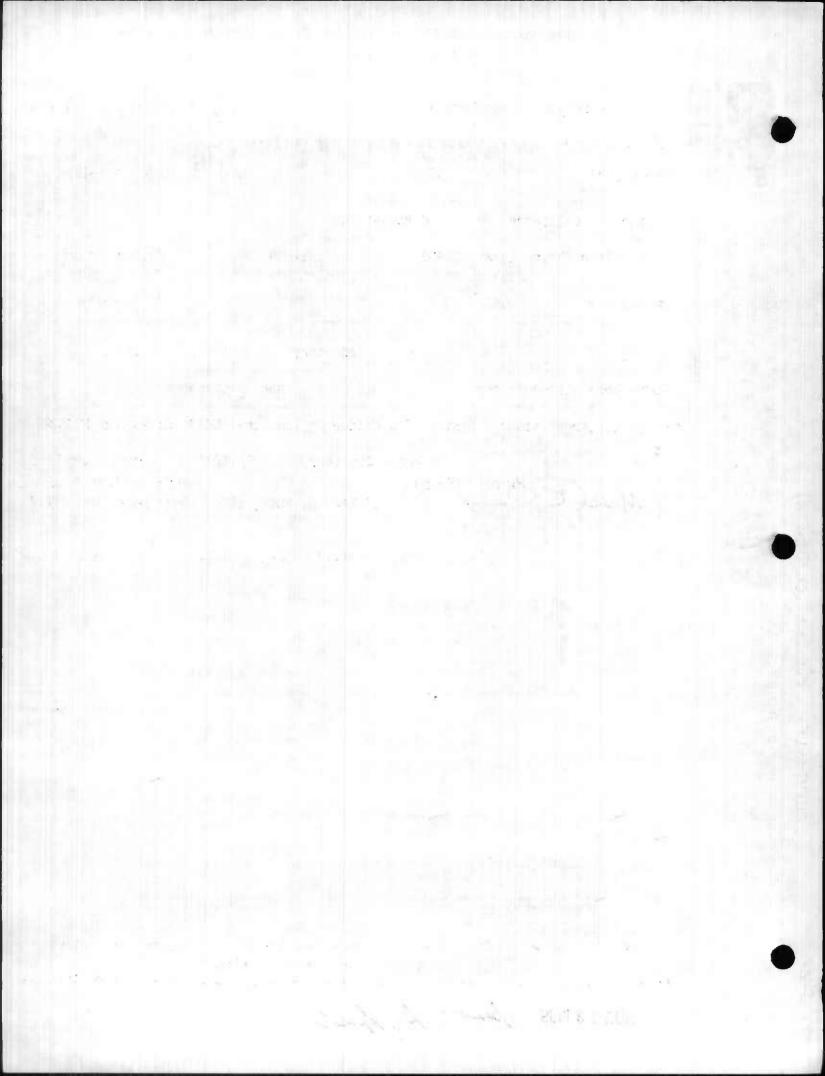
30. Neme and eddress of person who completed cause of death (item 23a) (Type, Print)

36-544 4999

St. Agner Hospital

August

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death (NME) ERNEST KAMM 10:00 Am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PARK AVE 4601 Ni CHEVY CHASE MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey. 5. Social Security Number 7. Age (fn yrs. last birthday) Birthplaca (State or Foreign Country) 124201964 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY CHEVY CHASE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PARK AVE 460/ N. USA 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PSYCHOLOGIST 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) BLAUSTEIN SAMM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAMM 4601 N. PARK AVE CHEVY CHASE MO FLORENCE (WIFE 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other piece) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stafe

22. Name and Address of Facility

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

D0045296

Connecticut Ave.

State Anatomy Board, 655 W. Baltimore St. Baltimore, MD 21201

Approximate Interval Between Onset and Death

23b. Did tobacco use contributa to the cause of death?

24e. Was an autopsy parformed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 | Yes 2 | → NO

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Kensington, MD 2088

8.8.99

1 Yea 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

Examiner

MD

4 Donation 5 □Other (Specify) 21. Signature of Funera) Service Licensee

Monald S. Wade, Director

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Cardio respiratory

Due to (or as a consequence of):

Progressive Suprove to (or as a consequence of):

Due to (or as a consequence of):

antrey disease

28b. Time of

28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

mellitus

28a. Date of Injury (Month, Dey Year)

Funeral

Director

r than "natural", or items 23s or 28s-f show the Wedges Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be fit, Department of Health and Mentel Hy Important: if Nem 27 is marked other any Injury or other traumatic event

altimore, Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vital

Funeral

à

Completed

Be

Physician/Medical Completed 8

Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical 27. Mannes of Deeth

and signed by I Medical Certification: To

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I

ABBAS, MA SHAHIMA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

5 Pending

Investigation

6 Could not be determined

Natural

2 Accident

3 Suicide

29e. Certifier (Check only one)

4 Homicide

32. Registrar's Signature

Alikas.

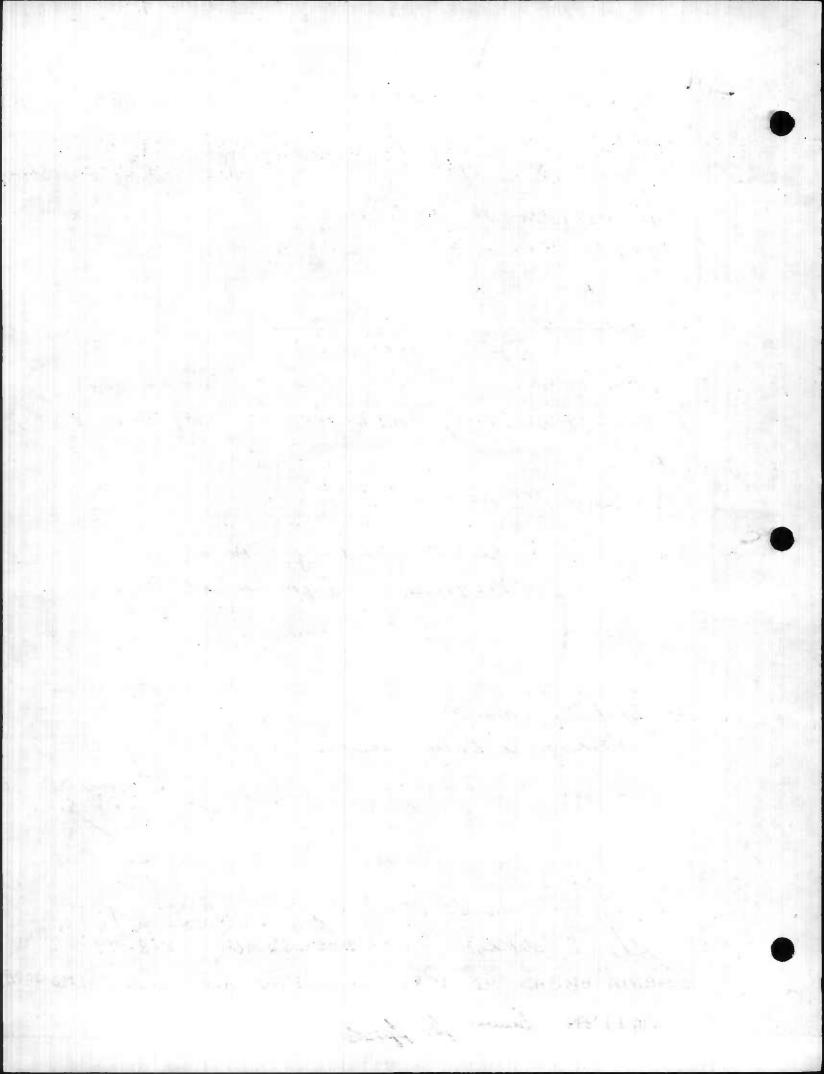
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810

ORIGINAL

DHMH 16 Ray 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth August 2:35 Am Melvin Lifsey 1999 10 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth NA Union Memorial Hospital Baltimore If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthptece (Stete or Foreign Country) 1□ M 2□ F Months Days Hours 64 216-32-6814 10-18-34 VA Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside Cttv Limits XXYes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21205 712 Wharton Court USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yeer or Deles: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuei Occupation 16b. Kind of Bustness/Industry (Give kind of work done during most of working life. DO NOT use retired) Eiementery/Secondery (0-12) Cotiege (1-4or 5+) B.G.& E. Co. Janitorial 10th Grade 17. Fether's Neme (First. Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Lifsey Rosetta Willie Lifsey 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 712 Wharton Court Baltimore, Maryland 21205 Rebecca Lifsey 20b. Ptece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete tery, cremetory or other pleca)
Zion Cemetery 08-16-99 1 Burial 2 Cremelion 3 Removei from Stete 4 Donetion 5 Other (Specify) Lansdowne, MD 21. Signeture of Funerel Service License 22. Neme end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enler the disease, or complications that caused the dean. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feliure. List only one cause on each line. Approximate Intervel Between Onset end Death Myocardial Immediete Ceuse (Finei nlarchica disease or condition resulting in deeth) Drzoise ue to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or trijury that initiated events resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24e. Was en eutopsy performed? completion of cause of death? 2/ No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. tnjury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1. Neturel 1 ☐ Yes 2 No 2 Acctdent 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steled.

| Medical Examinar: On the basis of examinetion end/or investigetion, in my optnion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated.

29c. License number

AT 2438946- PIS

29d. Date signed (Month, Day, Year)

10, 1999

certificate be executed Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifici To the Hospital within 24 hours a To the Funeral Completely filled

> State Registrar

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

7 is marked other than "natural", or frams 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

Peges 1 and 2 should be filed within 72 hours effer in ant of Health and Mentel Hygiene.

Int: If Hem 27 Is marked other than "natural", or ites iry or other traumatic event, the Medical Examination.

Department of Important: If any Injury or

Physician

/Medical

Examiner

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for use as 88

signed by the e

cate has t

director,

funeral

certificate

end

physician

Examiner

Physician/Medical

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Completed

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Certification:

edical

29e. Certifier

altimore, Maryland 21215-0020

the Maryland

death

AUG 13 1999

Non-

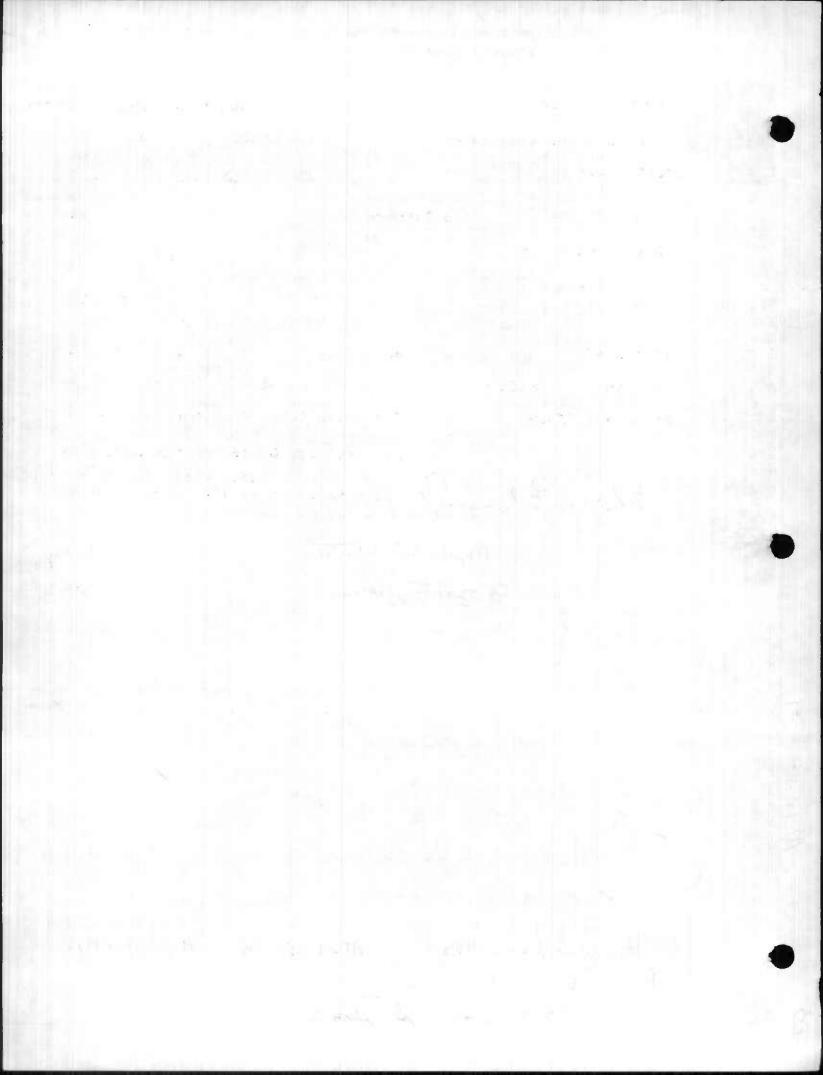
30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

29b. Signature,and title of certifier

31. Dete filed (Month, Day, Year)

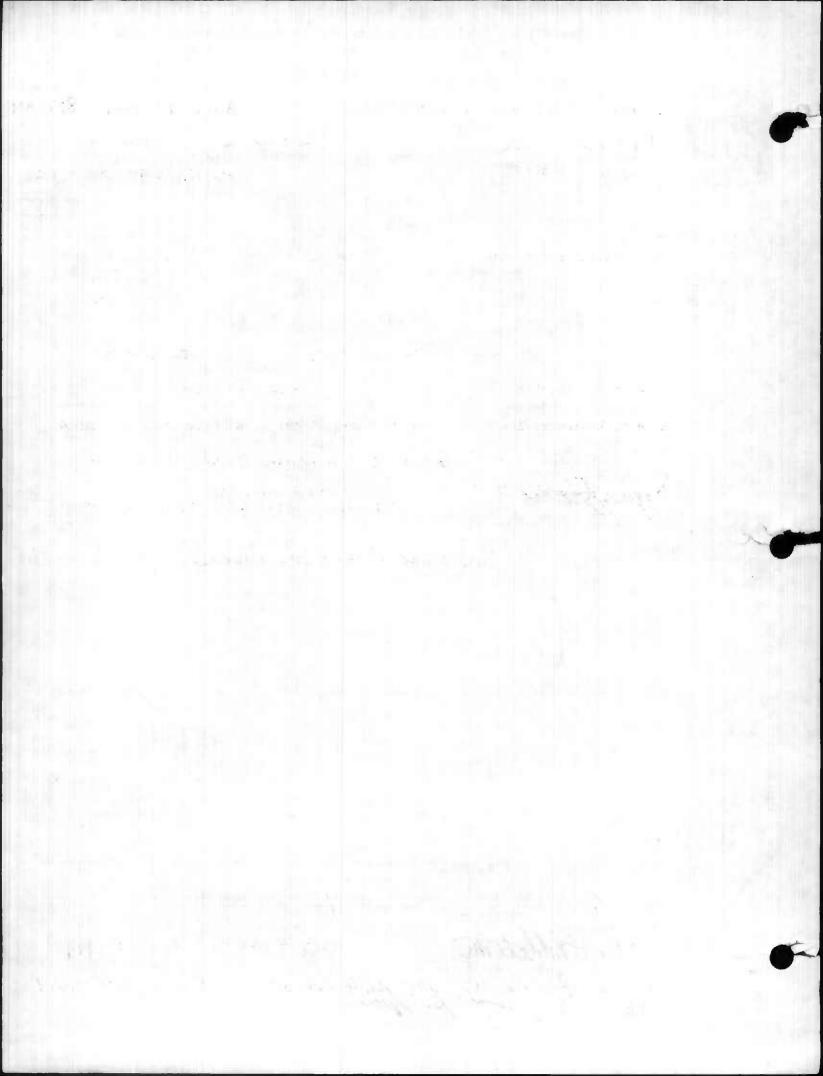


DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

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/Medical	JOHN SI	attnen La	wrer		4b. City, Town, or Lo	cation of Pheth	4c. County	799	8:45 AM
aminer	Vantage	11		7	Columb			were	
erai	5. Social Security Number	↑ OUS 7. Age (In yr	s. last birthday)	If Under 1 Yeer	If Under 24 Hrs.	8. Date of Birth (Month, Dey,			ace (State or Foreign
or	374-12-2334	XXM 2□F 79	Yrs.	Months Deys	Hours Min.	July 30	, 1920	West	Virginia
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5	10e. State 10b. County		City, Town or Lo					10	d. Inside City Limits 1 ☐ Yes 2 ☐ No
Directo	Maryland Howa	rd Co	olumbia	10f. Zip Code		1	0g. Citizen of W	het Count	44
ă	5400 Vantage Point Road			21044			U.S.A.	net Ooding	,,,,
Funerai	11. Meritel Stetus	12. Wes Decedent Ever in	U,S. 13.				14. Rece - American Indien,		
	1 ☐ Never Married 2 ☑ Man	Armed Forces? 1 Na 2 No If Yes, Give			en, Mexican, Puerto Specify:				
d by	3 ☐ Widowed 4 ☐ Divorced		1□ Yes 2□XNo	Specify: White			.te		
Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	16e. Decedent's Usuel Occupation (Give kind of work done during most of work)			king 16b. Kind of Business/Industr		
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	12 17. Father's Neme (First, Middle,	Last)	Nese	arch Anal	18. Mother's Name		Dept. o		ense
o Be	James Walton S				Alida De	na Schu	rman		
-	19e. Informant's Name/Raletions	-	19b. Mail	ing Addrass (Street	and Number or Rurs			Stete, Zip (Code)
	Ruth M. Lawre	nce/Wife	5400	Vantage	Point Roa	d Colu	lumbia, MD 21044		
	20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion	3 DRemovel from State	. Ptece of Disponentery, cre	osition (Neme of metory or other pla	ce)	Dete	20c. Location -	City or Tov	vn, State
	4 ☑ Donation 5 ☐ Other (S	pecify) A	natomic	Gift For	indation 8	/6/99	Laure1	, Mar	yland
	21. Signature 9/Funeral States	Licenseg		2. Neme end Addre		Tno			
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	23a Part Enter the disease, or shock or heart feilure. List	complications that caused the de only one cause on each line.	ath. Do not en	ter the mode of dyli	ng, such es cerdiac o	or respiretory err	est,	1	Intarvel Between
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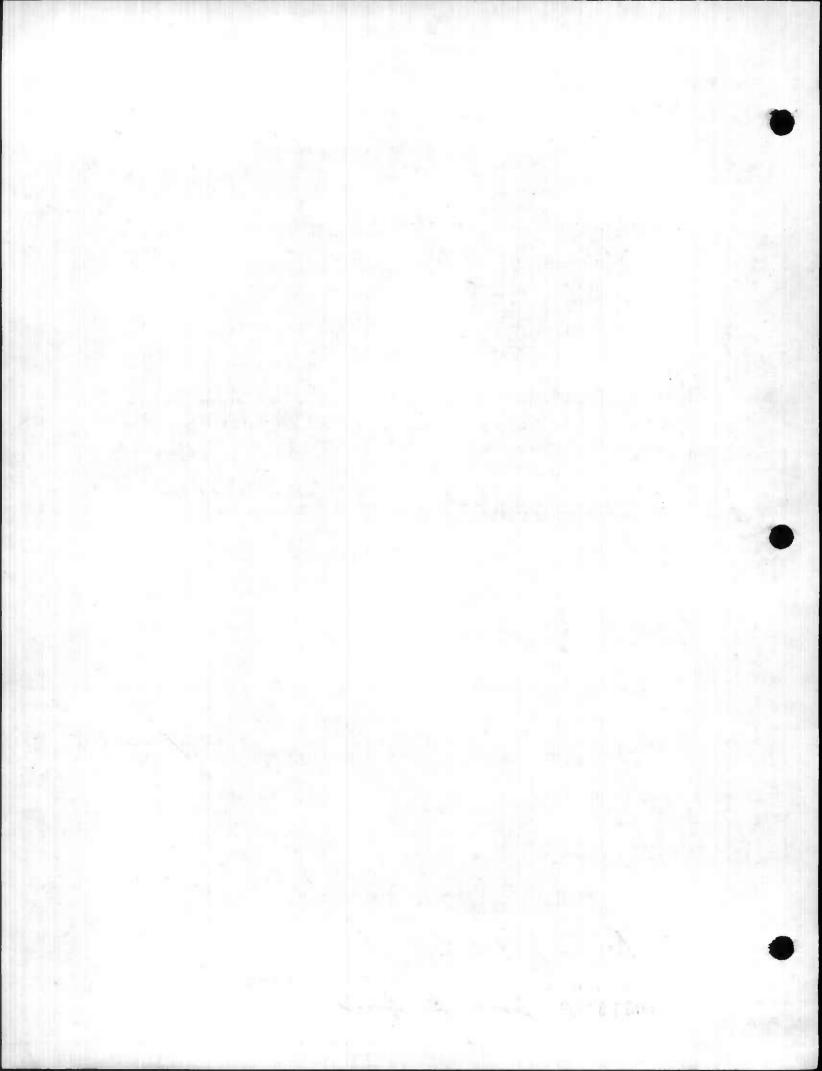
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State of Maryland / Department of Health and Mental Hygiene

LYL	ES JR.				Certificate of	Death	Be	g. No. 9 9	25	1493	
			1. Decedent's Name (First, Middla, Las	st)			2. Dete of Deet Month		Yeer	3. Time of Death	
•	Physici /Medic		Hlonzo L	4/85 /			AUGUST		999	5:03 PM.	
	Examin		4e Facility Name (If not Institution, give			4b. City, Town, or L	ocation of Death	4c. County	of Death		
			UNIVERSITY HO	DSPITAL		BALTI		n	IA		
	Funeral Director		5. Social Security Number 6. S 213-62-8756 1 Usual Residence of Decedent	ex 7. Age (In yrs.	Ast birthday) If Under 1 Yeel Months Days		8. Date of Birth (Month, Day, Morch 2,	Year) 1955.	9. Birthplac Country	Carolina	
	yland Mand		10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits								
	Men	tor	Marykal MA	R	Himore					1 HYES 2 No	
	th the		10e. Street and Number		10f. Zip Code		10	Og. Citizen of \	Whet Country	17	
	23a	Funeral Director	1717 Madison	Ave Hary	2/1	17		451	9		
	op E		11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Wes Decedent of tf Yes, specify Cul	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- Rican, etc.)		a - American ck, Whita, etc		
Baltimore, Maryland 21215-0020 Demrit. Pages 1 and 2 should be filled within 72 hours after death with the Meryland Department of Heelth and Mental Hygiene. Important: if them 27 is marked other than "natural", or home 23s or 28s-f show any injury or other traumetic event, the Medical Examinar must be notified at any object.		þ	1 ✓ Navar Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes:	1□ Yes 2☑No	Specify:		Specify	1	k	
50	72 h	Completed	15. Decedent's Ed (Specify only highast gra		16a. Decedent's Usual Occu (Give kind of work done	during most of world	king	16b. Kind of B	usiness/Indu	stry	
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Maryland	Mental F Mental F arked of atic eve	Be	DI Neme (First, Micora, East)			2 - // 3	ne (First, Middle, N	naideri Surnen	10)		
2	should be nd Mental marked c imatic ev	2	19a. Informant's Neme/Relationship (1	Tuna Print)	19b. Mailing Address (Stree	1/2/// C	my 18	City or Town	State 7in C	ada)	
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ē,	Heelth Heelth tem 27 other tr		20a. Method of Disposition	20b. P	lece of Disposition (Name of	on 1705,	Date :	20c. Location	City or Town	1, Stete	
OT.	Pages nent of nrt: If its iry or o		1 Burlal 2 Cremation 3 4 Donetion 5 Other (Specify	Hamovai from Steta	emetery, crematory or other pla	ece)	rigust 1	Balt.	mor	e,moi	
	Departm Departm Importan Importan Importan Importan		21. Signature of Funaral Service Licen	/ - /	22. Name end Addr	ass of Facility 77	211111	Tura	oral:	Service	
Ö	Departi Departi Importu any inju		10 IF 0	V 6	1201 me	Culloh	Street.	Balti	more	mo.	
			23a. Fart1. Enter the disease, or companies, or heart feilure. Liat only	olicetions that caused the deetl	n. Do not enter the mode of dy	ing, such as cardiac	or respiratory arre	est,	; A	pproximate	
8.	Physician		mock, or heart fellure. List only	one ceuse on each line.						nterval Between Onset end Deeth	
	/Medical		Immediete Causa (Final disease or condition	ACUTE NAR	COTIC INTOXICA	TTON					
Examiner			resulting in deeth)	о.	r as a consequence of):	IIION					
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	tificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions,	Due to (o	r as a consequence of):				İ		
90	cian c	E E	Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Disease or injury that initieted avents	C							
68760,	physi the	dici	that initieted avents resulting in death) Last	Dua to (or	r as a consequence of):						
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o	v requires that the death certification is should be deteched for use as		Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.			23b. Did tobacco use contribute to the car					
0	that the ded by desta						1 Q	8 2□ No	3 Proba	bly 45 Unknown	
Sp	sign old be	d by					24a. Was er	n autopsv	24b. Were	autopsy findings	
Peed need	shou shou	iete					perform			able prior to pletion of cause	
£ .	The law ste has b page 2 s	Completed					175 Ye	s 2 No	245		
VITAL IN INCIDENT THE CONTINUES IN PACTOR IN P	ification, pa	BeC	25. Was case referred to medical			26 Place of Dee	th (Check only one		75-	Pes 2 140	
> :	Physician: this certific ral director,	ToB	examiner?	Hospital: 1 ☐ Inpatient 2 🛣	ER/Outpetient 3 DOA	ther	ome 5 Reside		er (Specify)		
0	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Commissed by Dhysician		27. Menner of Death	28e. Date of Injury	28b. Time of 28c. Injury		28d. Describe ho				
0			investigation Tound atm 1 Tyes 2 MNo					UKNOWN			
N N			3 Suicida 6 Could not be determined 4 Homicide 6 Could not be building, etc. (Specify)				281. Location (Street and Number or Rural Route Number, City or Town, Stete)				
ā .			- La violinei de	1717 MADISON AVENUE, BALTO.,							
			FOUND IN HOUSE 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.								
			29b. Signature and pan of certifier	1 0.	29c. Licen	se number	25	9d. Date signe	d (Month, De	ıy, Year)	
PSPO			O.C.M.E.				Z	AUGUST 06, 1999			
1	2	-	30. Name and address of person who	ompleted cause of death (Item	23a) (Type, Print)						
1	M		Dennis J.	/ / /	ll Penn Street	, Baltimo	re, Mary	land 21	201		
	Stat	e	31. Date filed (Month, Dey, Year) AUG 1 3 1999	32. Registrer's Signa	9. Sports						
	Registra	ar	A00 T 3 1999	peny /	. Japanes						

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that the death certificate be exec Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certific

Physician

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Director

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Completed

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Examiner

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7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examinar must be notified at

the Marylend

death

permit. Pages 1 and 2 should be filed within 72 hours effer to Depertment of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or han any Injury or other traument.

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Certification: To

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Baltimore, Maryland 21215-0020

State Registrar

31. Dete filed (Month, Day, Yehr)

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29b. Signature and little of certifier

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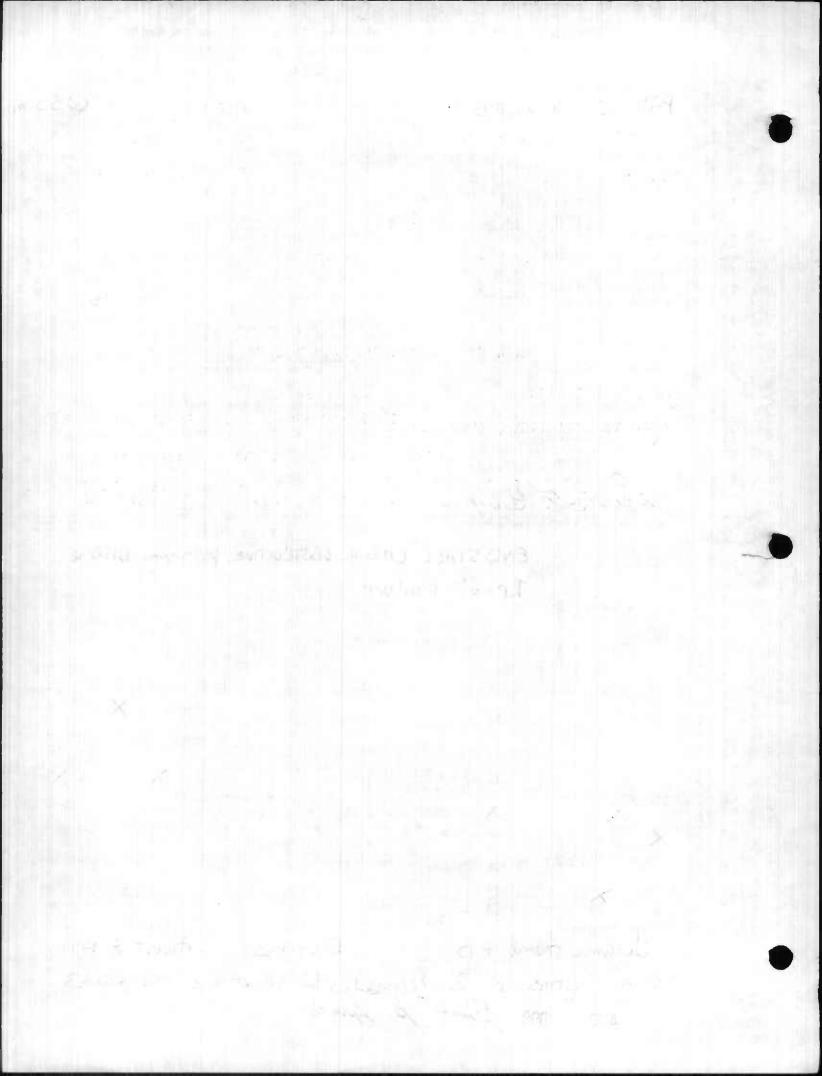
30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

Baltimore Md 21223

29d. Date signed (Month, Dey, Year)

29c. License number

DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** PATRICIA MC CALLUM AUGUSI 09 1999 13:07 pm /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death City, Town, ...

BALTI MORE
If Under 24 Hrs. 8. Date of Birth
Players Min. 4c. County of Death Examiner HARBOR CENTER HOSPITAL If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sax Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 Months 58 48 3352 Director Usual Residence of Decedent the Merylenc 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic evant, the Medical Examiner must be notified at Mary And Number 18ges 2□No Director 10f. Zip Code 10g. Citizen of What Country? 825 LINTWOOD 21225 USA Funeral deeth 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian, 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: If them 27 is marked other than "natural", or han Bieck, White, etc. 1 Never Merried Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify 2 Block 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) SE SKY CHEX Elementery/Secondary (0-12) College (1-4or 5+) Four Service Worker 12 4 6NVS 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Melden Surnama) Be SGRESA Whitworth With JERUME 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 33.00 StrEEL BALLINOTE. Md 21218 1709 E JEROME FU HIEV Date | 20c. Location - City or Town, State 8/13/9 Buller 20b. Place of Disposition (Name of cemetery, crematory or other p 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Bultmaix DUDOR Cencten 22. Nama end Address of Facility CAATHAN - HATTIS 21. Signature of Funeral Service Licenses 23a. Part Enter the of ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final a. Disseminated disease or condition resulting in death) Intravascular Coagulation Examiner Due to (or as a consequence of): Examiner Organ Failure buriel-transit certificate be executed pue Sequentially list conditions, if any, laeding to immadiate cause. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Immuno deficiency physician Acquihed 40015 Physician/Medical the Dua to (or as a consequenca of): 80 980 signed by the a 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 ☐ No 3 □ Probably 4 K Unknown þ 24b. Were autopsy findings available prior to Completed 24e. Wes an autopsy completion of causa of death? pege 2 1 Yes 2⊠No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) To 1 ☐ Yes 2 ☑ No 1 SInpatient 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred After 5 Pending Injury 1 Natural after death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homloide 24 hours a 29e. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature end title of cartifia 29c. License number 29d. Dete signed (Month, Day, Year) REPIDENT. 12797 AUGUST 09

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30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

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32. Registrer's Signature

MRA

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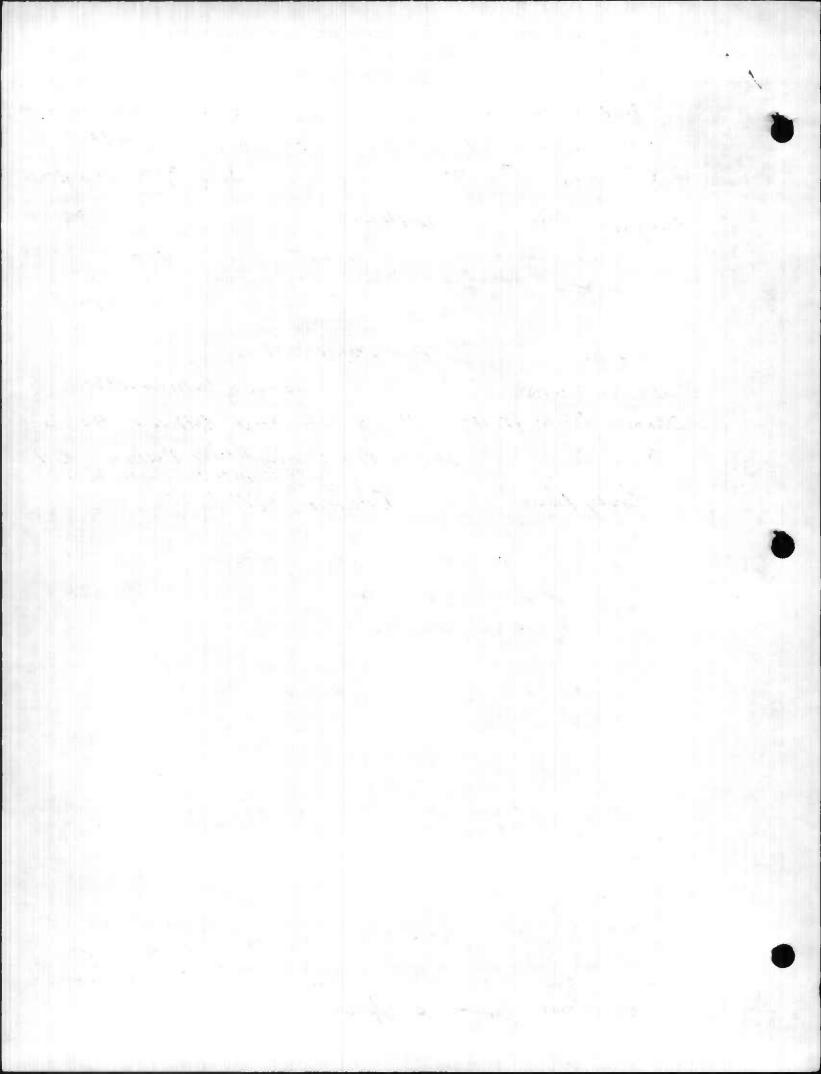
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31. Date filed (Month, Day, Year)

Registrar

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State



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth IN) MEYERS Month **Physician** CHRISTINE 545 AM AnamsT 10 1999 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner HOSPITAL SAMARITAN BALTIMORE BALTIMORE GOUN If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 20 F Months Deys 212 -42-7518 1942 Marylans Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits BALFINOYE 1 Pres 2 No lary bro Directo hems 23s or 28s-finer must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11512 3/20 RAVENWOOD Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes ▷ No
If Yes, Give
Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Merital Stetus the Medical Examiner Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No 9 Maryland 21215-0020 Specify: B/ack Specify: þ 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiona. other than Elementery/Secondery (0-12) College (1-4or 5+) MULDCIZ MACHINE OPERATIV 124600 lashes 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be h and Montal h pernit. Pages 1 and 2 should be 1 Department of Health and Mental Important: if flew 27 is marked of HEZEKIAH INEZ JUNES 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address_(Street and Number or Rural Route Number, City or Town, Stete, Zip Code) CoHmon RAUGNAGOD WAYNE CO HUE Bolto 464, 14 212-13 altimore. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete Burial 2 Cremation 3 Removel from Stete Woobcour, Kinglans 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility CHATOLOGY Lamb 21. Signeture of Funeral Survice Lights #3a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, of heart failure. List only one ceuse on each line. Approximeta Interval Between Onset and Deeth **Physician** BREAST /Medicat METASTATIC CANCER tmmediata Cause (Finel disease or condition resulting in deeth) Examiner Examiner physician and the bunal-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequenca of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by DIABETES 1 Yaa 2 No 3 Probably 4 Unknown by HEART FAILURF 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Be Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Pinpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred 5 Pending investigation 1 (DNetural he Hospital or Attending in 24 hours after death. he Funeral Director: Afte 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and dua to the cause(s) and manner es stated. (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner steted. Vithin 2 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 0047891 MD August

State Registrar

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31. Dete filed (North Pax, Year) 1999

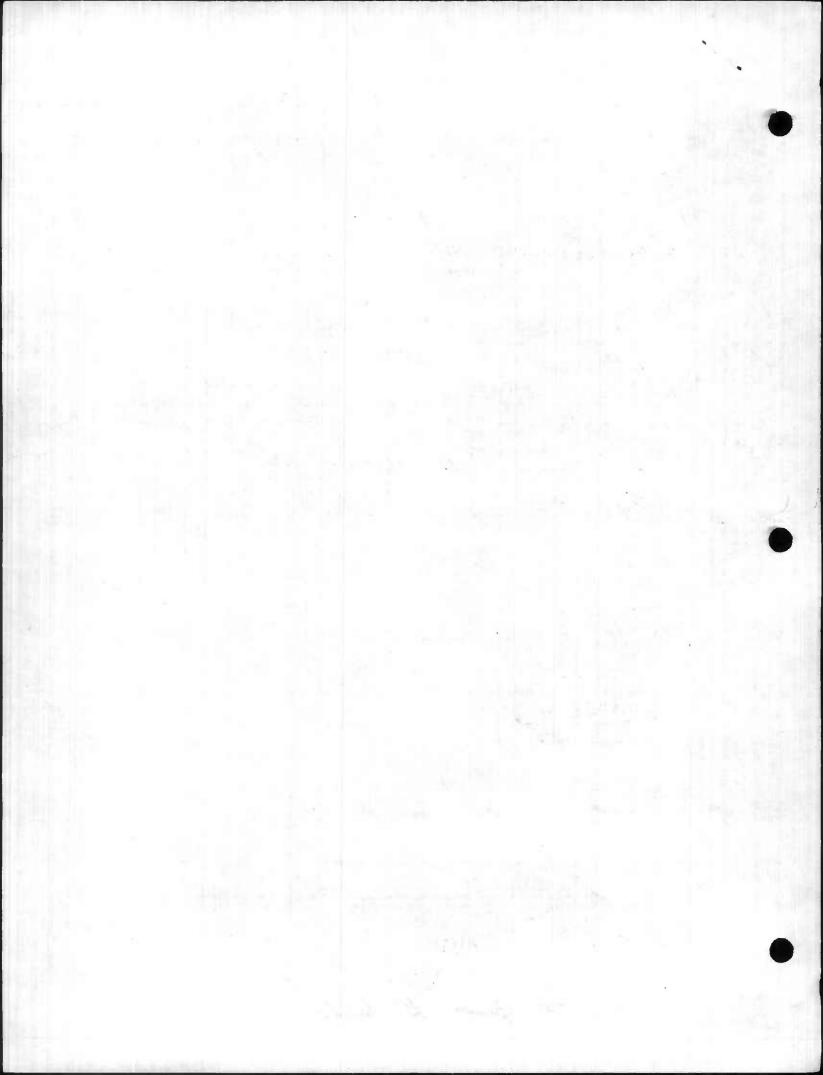
30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) ERIC 0. AIGBEDID N GVD D

32. Registrer's Signeture

oaks

SAMARITAN HOSPITAL

BALTIMORE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** Yaar 1999 5:30 P.M 1 /Medical 4e Facility Nama (If not institution, giva street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner imoRE If Undar 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sax Birthplace (Stata or Foreign Country) **Funeral** Months Hours 1□M 250F Yrs Usuel Residence of Decedant **Director** 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or frems 23a or 28a-f shorte Medical Examiner must be notified at 1 Yas 27 No Director PARTAM 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3125 21083 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Wes Decedent Ever in U.S. Armed Forcas? 11. Marital Status 14. Race - American Indian, Black, Whita, atc. 1 Never Merried 2 Married 1 Yas 2 M If Yas, Giva Yaar or Datas: 2M No altimore, Maryland 21215-0020 1 Yas 2 No Specify: P 3 Widowed 4 ☐ Divorced WHIT Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pemit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: if frem 27 is marked other than any Injury or other traumstic avent, the Me Elementary/Secondary (0-12) Collega (1-4or 5+) AM 3768 KER 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be To XAVIS ASTER SMI FRANK UKTZAZ 211102 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) 19e. Intormant's Name/Ralationship (Type, Print) SHRZWSBURY GENZ BIRRIDRIVE 2/1/3 20b. Place of Disposition (Nema of 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata cematary, cramatory or other place) AUG.11, ↑ Burlal 2 Cramation 3 Removel from Stete 4 □ Donation 5 □ Other (Specify) OHA'S CHURCH! 1999 LOOK GREEN PLANTAGE 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licensee 12MORILS LHAPLI 21234 8800 HARFORD 1887 LACO Approximate Interval Batween Onsat and Death 23a. Part 1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tailure. List only one ceuse pry each line. **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical weeks Examiner Dua to (or as a Consequence of) Examiner burial-transit Sequentially list conditions, if any, leading to immadiata ceuse. Entar Underlying Ceuse (Disease or injury that initiated avants resulting in death) Last pue Due to (or as a consequence of) Records, P.O. Box 68760 sertension Physician/Medical Due to (or es e consequance ot): Compression ractures osteo signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Page 1. 23b. Did tobacco use contributs to the cause of death? Yes Yes 2□ No 3 Probably 4 Unknown p cate has been sig , page 2 should b 24b. Were autopsy tindings svailable prior to completion of ceuse of death? Completed 24a. Wes an autopsy 1 Yas No 1 Yas 2 No certificate Division of Vital or Attending Physician: Be (director, 25. Was casa ratarrad to medical 26. Place of Death (Check only ona), GRADOQUINTIR'S Other: 4 Nursing Homa 5 Rasidence 628Othar (Specify) edical Certification: To 1 Yas 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural
Accident Injury 5 Pending as after dea. death. 1 ☐ Yas 2 ☐ No invastigation 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Plece of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 4 Homicida To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Certifying Physician: To the best of my knowledga, daath occurred at tha time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifiar 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifian 29c. Licensa number

DHMH 16 Rev 6/95

State Registrar Min

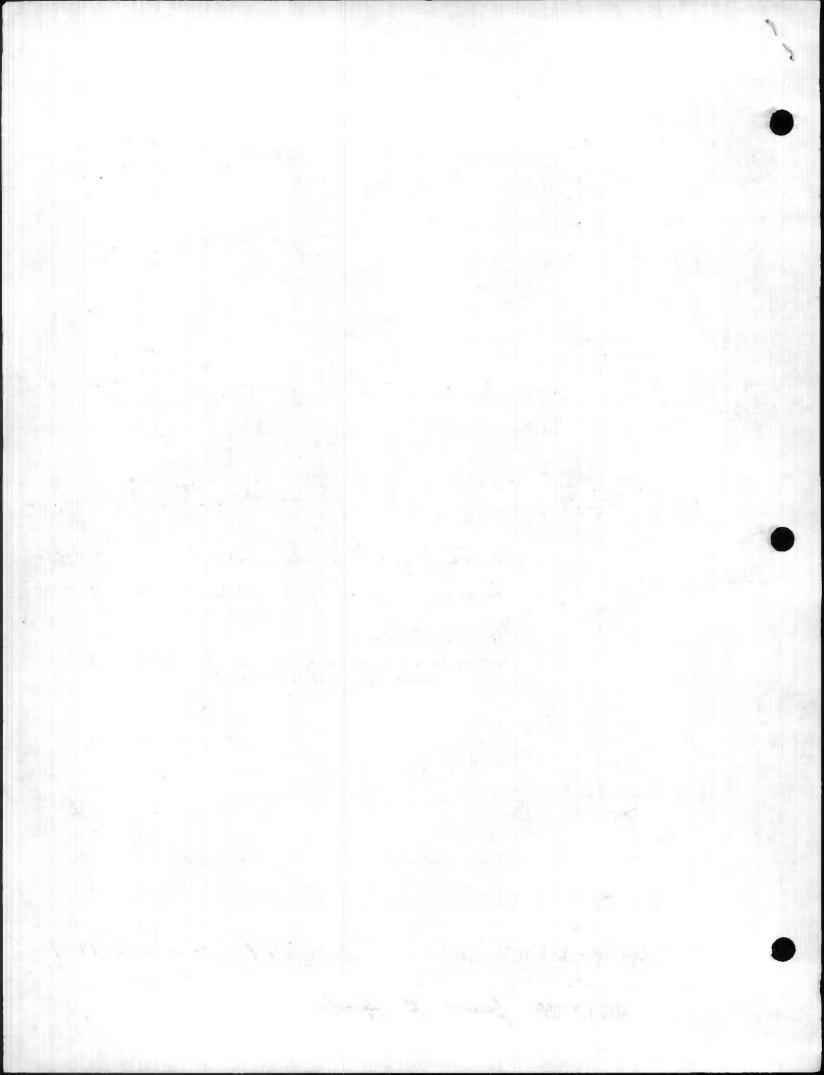
32. Pegistrar's Signatura

30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

31. Data tiled (Month, Day, Year)
AUG 1 3 1999

lugust 10,

21047



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#7&8 PER F.H. G774 8-19-99 J.A. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MURDOCK 11 1999 4c. County of Death 11:10 AM MOLLIE AUGUST 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death BALTIMORE None If Under 24 Hrs. Hours Min. 8. Defe of Birth (Month, Day, Year) 1917 Country) June 24, 1919 Maryland SINAL BALTIMORE a (In vrs. last birthday) If Under 1 Year HOSPITAL OF 7. Age (In yrs. last birthday) 80 82 yrs. 5. Social Security Number 1□ M 20 F Months Days 216-16-3209 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3007 Lawina Rd. 21216 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: Specify: **Black** 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Domestic Private Homes 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Henson Mary Smoot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rebecca Gross/Daughter 3007 Lawina Rd. Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Mt. Zion 8-14-99 Landsdowne, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility The Derrick C. Jones Funeral Home 4611 Park Heights Ave. Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): FAILUIRE HEART CONGESTIVE Sequentially list conditions, if any, leading to Immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf Due to (or as a consequence of): DEMENTIA Due to (or as a consequenca of): 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed physician e s the buriel-Box 68760 28 986 the 2 Division of Vital Records, Deed page 2 hes certificate Attending Physician: director, this After this death. or Attend effer death Director: 24 hours eft Funeral Di letely filled in

Physician

/Medical

Examiner

Funeral

Director

rail, or items 23s or 28s-f show Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter death v
Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s, any Injury or other traumatic event, the Medical Examiner mans and

Physician

/Medical

Examiner

Physician/Medical

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Completed

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Certification: To

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Funeral

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due fo the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the fime, date and place, and due to the cause(s) and manner stated.

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) AUG 1 3 1999

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29b. Signature and title of certifier

SINAL



angarlen

29c. License number

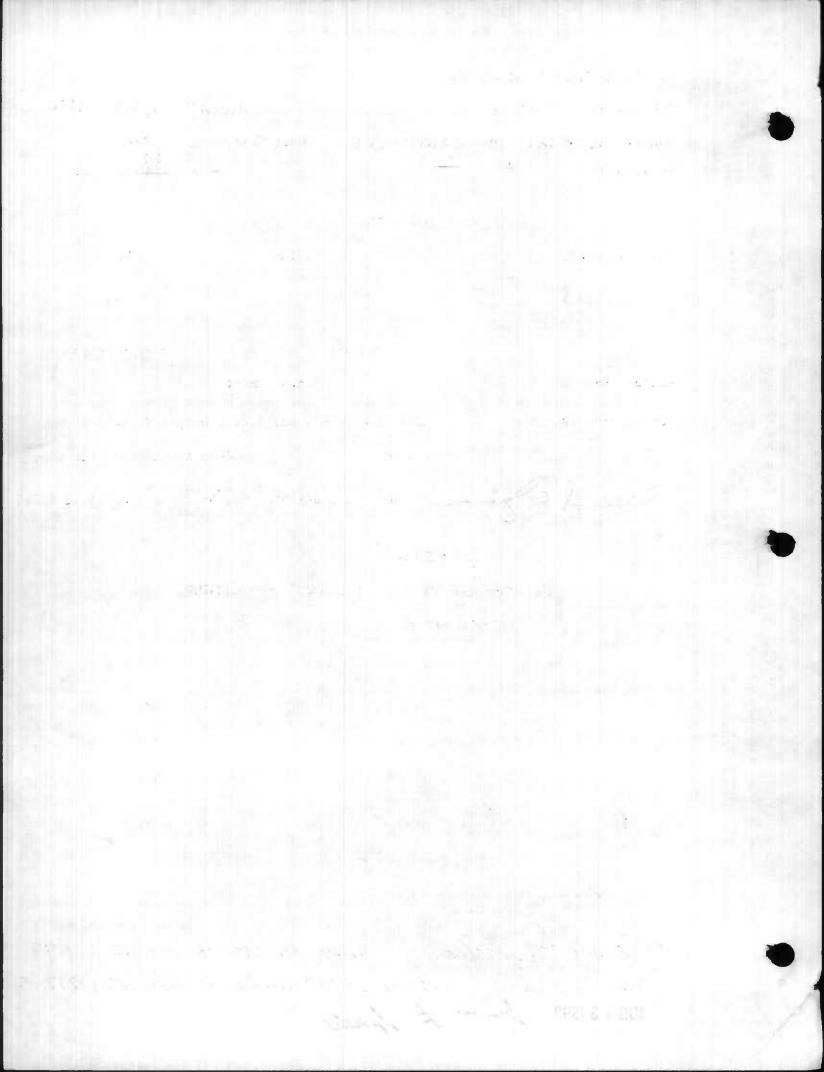
29d. Date signed (Month, Day, Year)

AS2402321-SP9ZOB AUGUST 11, 1999

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within 2

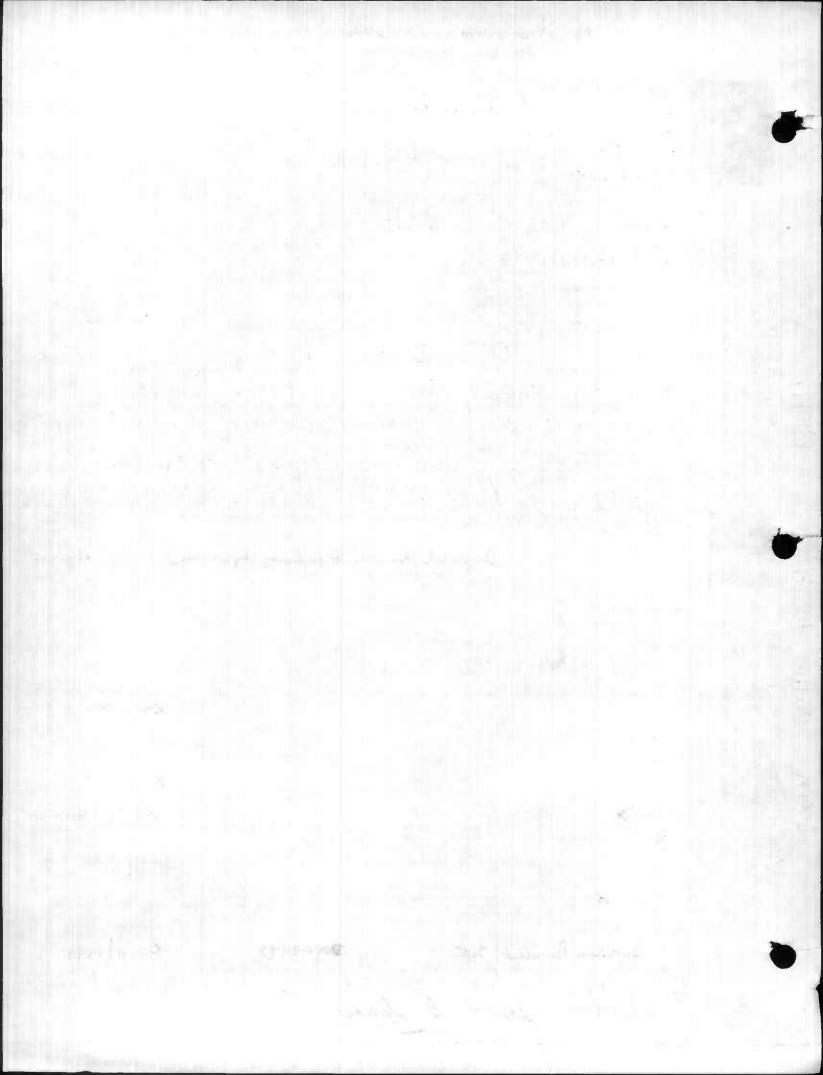
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4b, City, Town, or Location of Death 4c County of Death 4a Facility Name (If net institution, give street and number) **Examiner** 0 0 6. Sex 100 M 2□ F Birthpiaca (Stata or Foreign Country) -732 7. Aga (In yrs. last birthday) 8. **Funeral** Months Days Vania Director Usual Residence of Decedent the Marylend 10b. County 10a. State 10c. City Town or Location 10d. Inside City Limits from 27 is marked other than "natural", or frama 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director laryland 10a. Sfreet and Number 10g. Citizen of What Country 10f. Zip Coda ove permit. Pages 1 end 2 should be filed within 72 hours after death Department of Health end Mental Hygiene. Important: If flem 27 le marked other than "natural", or terms 23. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amaricen Indian. 11 Marital Status Black, White, etc. 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates: 1 Navar Marriad 2 Married 1 Yes 2 No Specify: 0 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry ng most of working Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 10 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Informant's Name/Reletionship (Type, Print) (mother) 20b. Place of Disposition (Name of cemetery, crematory or pither p 0 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) Crematori 21. Signature of Funeral Service License 22. Name and Address of Facility) Josep LUR. Vor the the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, heart in time. List only one ceuse on each line. Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) Immune Deficiency Syndrom Examiner 5 Due to (or as a consequence of): Examiner the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or as a consequence of): 88 USB 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 3 Probably 4 Unknown 1 ☐ Yee 2 No þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? hes Mdash 2 No After this certificate 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) How price 10 1 Yes 2 No 1 Inpatient 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b Time of 28c. injury et Work? Certification: or Attending Netural 5 Pending investigation 2 No death. 1 Yes 2 Accident aftar deatl 6 Could not be determined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and mennar stated. edicai 29a. Certifier 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year) 10008583 William Benedict, Ins 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 1.209 AUG 1 3 1999 32. Registrar's Signature State

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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25500 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Emily Theresa Markelonis August 08 1999 8:40PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 10 M 20 F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Yrs 215-03-5598 82 Director 11/ 06/ 1916 Maryland Usual Residence of Deceden the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7232 German Hill Road 21222 USA Funeral 2 should be filed within 72 hours after death and Mental Hygiene. Is marked other than "natural", or frams 23. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Saltimore, Maryland 21215-0020 Specify: White Aq 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Assistant 8 Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John Skabisky Mazelauskas 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum George J. Markelonis Jr. /Son 1014 Passamaguody Harbor Pasadena Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Louden Park Cemetery 08/12/99 Baltimore Maryland 21. Signature of Funeral Service License David J. Weber Funeral Homes PA Kathleen 5311 Edmondson Ave. Baltimore Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Physician tmmediate Cause (Final disease or condition resulting in death) /Medical hours Acute myocardial infarction Examiner Due to (or as a consequence of): Examine vears Ischemic heart disease sician and Durial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Due to (or as a consequence of): ed by the attanding physician detached for use as the burla Hypertension years 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): Box P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yea 2 No 3 Probably X∑Snknown Dementia Division of Vital Records. ģ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? certificate has 1 Yea 2 No 1 TYes 2 TNo 25. Was case referred to medical 88 26. Piace of Deeth (Check only one) Hospitel: Other: X版 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yest 2010 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manger of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Ather Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 C Homicide To the Hospital
within 24 hours a
To the Funeral D
completely tilled >Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. edical 29e. Certifier 250, Signature and title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number an'com. D08358 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registra

Gracito V. Patricio, M.D.P.A.

11. Date filed (Month, Day, Year)

32. Registracs S

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32. Registrac's Signature

8903 Harford Rd., Baltimore, Md.

